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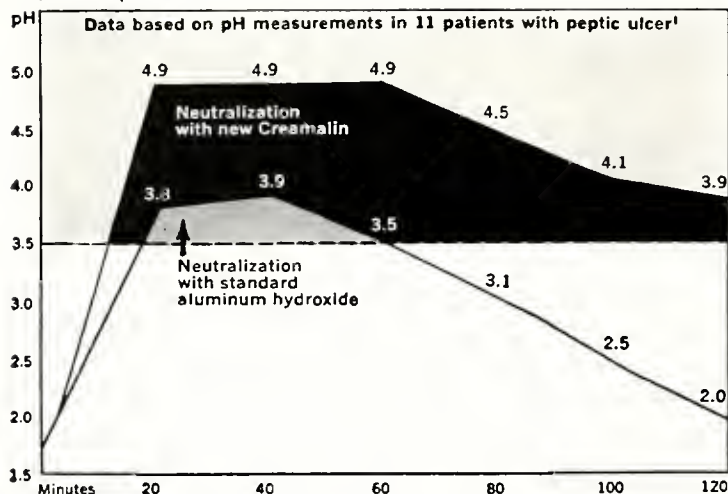


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1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: J. Am. Pharm. A. (Scient. Ed.) 48:384, July, 1959.

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NORTH CAROLINA MEDICAL JOURNAL

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VOLUME 22

JANUARY, 1961

No. 1

Scientific Progress Is Spelled A.M.A.

LEONARD LARSON, M.D.*

BISMARCK, NORTH DAKOTA

Ours is an age of wonders. Ours is an age that needs no adjectives to describe it. Without doubt, our civilization, our culture and our knowledge have far surpassed any previous high points in history. But unlike Voltaire's Professor Pangloss, I by no means feel that "all's for the best in this best of all possible worlds." We have progressed beyond man's previous efforts in almost every aspect of life. Or if we have not progressed, we now possess the power to do so. We have achieved much, but we certainly cannot settle back thinking that no further progress is possible. The threat of nuclear annihilation is still a serious one. Man's relations with his fellow man still show streaks of savagery and brutality. Cancer and heart disease still take a heavy toll of human lives. And perhaps the worst commentary on our present-day enlightened civilization is that thousands die unnecessarily each year on the nation's highways.

But of course the *progress* of man and his mind is much more delightful to contemplate. Science has delved into the earliest history of the world, investigating the origins of life and the descent of the human species. Within the last few months, a major epoch in the science of astronomy was reached with the opening of the observatory-receiving center at Green Bank, West Virginia—designed to draw evidence of the possibility that life, intelligent life, exists elsewhere in the cosmos. To me, this repre-

sents one of the most important scientific steps in our century. It is far more than a page from a Buck Rogers comic book, but rather represents the serious belief of intelligent scientists that intelligent life is quite possible in other galaxies.

But I do not want to wander too far from the subject I am most interested in—medical progress, the ultimate defeat of disease and suffering, and the better health of everyone—these are the goals of the organization I represent, the American Medical Association.

Purposes and Functions of the A.M.A.

What is the American Medical Association?

What does it do for the public and for the physician?

These are questions a great many persons ask; too few can give the correct answers. Too seldom do I have the opportunity or the time to explain the workings and purposes of the A.M.A. Today I want to give you some idea of the American Medical Association.

A Vehicle for Better Health

Let me begin by comparing the A.M.A. to an omnibus. By definition an omnibus is a vehicle designed to carry or serve a large number of passengers. It stops everywhere; it serves everyone. The A.M.A. is similar in many ways. As a vehicle for the promotion of better health, it serves all Americans. It does everything it can to help people with their health and medical problems.

Yet its service is even greater than the

Delivered before the Raleigh Rotary Club, Raleigh, North Carolina, May 9, 1960.

*Chairman, Board of Trustees, American Medical Association.

usual omnibus. It does not travel only one specific route, but travels every sound medical and health route. As the A.M.A. omnibus daily travels the highways and byways to better health for all Americans, it provides many things for many individuals:

—At the industrial plant A.M.A. and its Council on Occupational Health assist in the reduction of industrial accidents and diseases.

—At the drug store the A.M.A. and its Council on Drugs aid the druggist by providing reports on the reliability, proven therapeutic value, and limitations of drugs.

—At the newspaper office the A.M.A. aids in the preparation of factual health articles and cooperates in the development of press codes with the doctors in the community.

—At the school the A.M.A. touches the lives of almost every child through its work with the National Education Association on school health and nutrition, including school lunch programs.

—At the grocery store and the bakery the A.M.A. is associated directly or indirectly with the health and nutritional standards of food.

—Police and fire departments know the A.M.A. for its help in curbing accidental poisoning and in probing the medical aspects of crash injuries.

—The lawyer is acquainted with the A.M.A., for the two professions are working together for the proper preparation and use of the medical witness, the adoption of interprofessional codes of understanding, and the answering of the baffling questions of narcotic addiction.

—Even the insurance man sees the work of the A.M.A., which for many years has been encouraging the development of voluntary prepaid health insurance plans.

And so it goes—from infancy to old age, from work to recreation, and from food to drugs—the A.M.A. plays a daily role in promoting and maintaining the health of all Americans.

Achievements of the Past Year

Last year the American Medical Association undertook scores of projects in the public interest. It fought for certain principles,

ideas, and causes. It waged nationwide campaigns for the better health of all Americans.

Last year, for example, the American Medical Association:

—Warned the public about the dangers of plastic bags.

—Waged a heavy attack on food fads, on weight reduction products and methods, and on nutrition and cancer quacks.

—Opposed compulsory retirement and job discrimination because of age. Urged a nationwide campaign of jobs for the aged.

—Continued its 1958 efforts to have everyone under 40 inoculated with the Salk vaccine.

—Encouraged the development of dozens of new health insurance plans to cover the nation's elderly citizens.

—Exposed the dangers of the use of amphetamines—or "pep pills"—in athletics. Initiated a program to reduce injuries in school athletics.

In schools, factories, urban and rural areas, hospitals, medical schools and physicians' offices the A.M.A. continued disseminating health information and striving for better health in America.

We worked in such fields as aging, foods and nutrition, hypnosis, cancer, mental health, heart disease, household poisons, physician placement, maternal child care, rehabilitation, national defense, and nursing homes.

Without a doubt, our greatest ally in providing this medical and health information to the public was the nation's newspapers. Through the cooperation of the press—and I must include radio and television—our Association was able to propagate health education throughout the nation.

Correcting Misconceptions About the A.M.A.

As you know, our Association occasionally has been criticized for being too conservative.

I make no apologies for our conservative attitude and approach to many issues. Physicians by professional training are conservative. We deal with human lives and human health, and must stick with the "tried and true" methods in most instances.

Let me make one thing clear, however. The American Medical Association definitely does not oppose *change*; indeed, it welcomes change if the new is better than the old. But let's hear an objective viewpoint on this subject. Not long ago, Julian DeVries—a newspaper columnist for the *Arizona Republic*—devoted a column to refuting popular misconceptions about the A.M.A. These are his words:

Long have we been informed, by word of mouth and by epistle, that the aforementioned A.M.A. is a right little, tight little union which can do no wrong, and which controls not only the practice of medicine in these United States, but those who practice it, as well. This, to be as charitable about it as truth will permit, is a complete, utter and unsubstantiated falsehood.

The American Medical Association controls no one and no thing. It investigates. It establishes standards. It recommends. But it does not order. It does not dictate. It does not raise as much as an eyebrow in restraint. It is completely at the service of the doctor and, through him, his patients.

Later in his column, the writer deflates the claims of quacks that the A.M.A. suppresses their marvellous wonder cures. "Stuff and nonsense," he writes. "The A.M.A. couldn't suppress as much as a sneeze, even if it wanted to, and it doesn't want to." It certainly is refreshing to read such a different newspaper column!

Another item to note well is that the American Medical Association is neither a do-nothing nor an apathetic organization. It is busy every day of the year in hundreds of projects for the public, for medical science and for physicians. We are continuing to develop programs that will benefit the American public, especially in the problem areas of medicine and health.

One of these is medical care costs.

The American public, and rightly so, has an intense interest in the costs of medical care. These costs involve people's lives, health, and pocketbooks. But the mass of written and spoken words frequently produces confusion and misinterpretation in the field of medical economics. Quick and easy information—sometimes erroneous information—is available from persons who may be adept at statistics, but who lack a

thorough knowledge of all the medical and human elements that go into health care.

All this exposes a basic philosophy which is extremely difficult to combat. No one wants to be ill, and no one wants to think of being ill. Therefore, it is distasteful to pay for the costs of getting sick. There is nothing more desirable than to admire a fine TV set, a new car, an expensive suit of clothes; there is nothing to enjoy like a gay party, a theatre, or a sports event. The motivation is quite different when it comes to meeting the expenses of illness. It certainly is more fun to buy a TV set or a new car than to pay a doctor's fee or a hospital bill.

Yet, when people get sick they demand—and get—the finest medical and hospital care in the world. And good medical care *is* costly—there is no way of getting around it. Actually, the cost of medical care may be higher in terms of dollars than it used to be, but the same applies to everything else.

From the public's standpoint, the big difference is that it receives a vastly superior product, medically, than it did 20 years ago. That it is superior is testified by the tables for life expectancy. In 1920 newborn babies could expect to live 55 or 60 years. Today the average life expectancy is 70 years.

Are hospital bills, and doctors' bills, and drug bills too high? Is the price of meat, or haircuts, or automobiles too high? Are stocks too high or any other commodity or service too high?

The people of the United States have an automatic, built-in deterrent when something becomes too high. When it really is too high we stop buying it and the price drops in the face of competition.

Certainly this is true in the field of medicine—for any physician can easily price himself out of the market for his services. If the doctor wants \$300 for an operation that an equally good man will do for \$200, he soon finds that the laws of economics apply very swiftly. And the same applies to the price for house visits, consultations and on and on.

Is the cost of health care too high? By all economic yardsticks it is not—not while

more and more people buy more and more insurance for more premiums to pay their bills for illness, not while people demand more and more services from hospitals and will pay for them, and not while patients demand more and better care from their physicians and will pay for this improved service.

A Better Product

Ironically, the success of medical advances is one of the main causes of higher medical bills for many families. Tens of thousands of people are alive and able to work because doctors now prevent or successfully treat such things as pneumonia, polio, tuberculosis, heart ailments, and other ills which were once fatal. But, as a direct result, more and more people are living on into a time of life when long and costly illnesses are likely to occur.

Basically, the rising cost of care can be traced to relatively new elements—new drugs, improved techniques, materials and equipment. Also there are the salaries of specialists and technicians skilled in only recently developed fields, with the result that the whole medical package now is bigger, better—and more expensive.

The problem is to try to find a way to keep medical bills from becoming an impossible burden, without halting the progress of medical science. It is easier now to keep from getting ill, to recover more quickly once illness hits, and to maintain your health after you regain it. But the discoveries that make it possible cost money, so the cost of getting sick—and getting well again—keeps going up.

Commission to Study Medical Costs

To learn where economies may be achiev-

ed, the American Medical Association recently announced the formation of a commission to study the cost of medical care. Backed by an initial A.M.A. grant of \$100,000 this commission will analyze the cost picture from every angle. The A.M.A. is tackling the cost problem to help people better meet their obligations when illness strikes, and also to help clarify the confusion that exists about such costs. The Commission will study *all* medical costs, drug expenditures, and health insurance premiums. I consider the creation of this commission by the A.M.A. as further tangible evidence of medicine's sincere regard for the most important individual—the patient—and his well-being.

Conclusion

As you see, the A.M.A. omnibus travels far and wide to help you and all Americans with health and medical problems. I have described only a few of the hundreds of A.M.A. services. I could go on and on.

I could tell you about our promotion of science fairs for high school students; our studies of aging, alcoholism, mental health and rehabilitation; our inquiries in the new fields of aviation, atomic and space medicine; our efforts to train more and more students for medical and allied careers, or our enormous work with medical schools and hospitals and in the fields of nutritional, mechanical and cancer quackery.

As a physician I am proud of the American Medical Association and its services to the citizens of Raleigh and every other city across the nation. As a Raleigh resident who benefits from the work of the Association, you too can be proud of the A.M.A. because your doctors are part of it.

A Group of Uncommon Pulmonary Diseases

SYLVANUS W. NYE, M.D.

and

WALTER R. BENSON, M.D.

CHAPEL HILL

Tuberculosis and carcinoma remain as the two most common diagnoses made of lungs or portions of lungs surgically removed for pathologic study. Occasionally, however, other less common diseases are encountered. Some of these resemble tuberculosis, or one another, and differentiation is of considerable importance to the welfare of the patient.

In the past three and one-half years we have studied a number of these uncommon disease processes during the examination of 545 specimens, consisting of lobes, segments of lobes, or lungs. The majority of these specimens (289) were received from the staff at the North Carolina Sanatorium, McCain. A slightly smaller number (255) were received from the staff at North Carolina Hospital, Chapel Hill, and one from St. Luke's Hospital, New Bern, North Carolina. Table 1 lists the various types of disease processes.

Fungi

Fungi are an interesting group of organisms causing pulmonary diseases, some of which often simulate tuberculosis clinically, radiologically, and pathologically. The various types we have seen in this study are listed in table 2. Actinomyces and blastomycosis will not be discussed.

A. Histoplasmosis

The lesions of histoplasmosis in some patients occur as isolated nodules or coin lesions, simulating a tumor or a tuberculoma. In other patients, the lesions may be multiple and resemble disseminated fibrocaceous tuberculosis. Three patients presented with isolated nodules and one patient (studied at autopsy) presented with the more disseminated form of the disease.

Case 1: The patient was a 36 year old man who had had malaise and weight loss (20 pounds) for the previous nine months. One month before operation a pleuritic pain developed suddenly in the right side of the chest, and lasted for three or four days. He had no other symptoms. Fever (up to 102 F.) began at the same time and persisted.

On physical examination the patient had an erythematous papular eruption, which developed while he was receiving an antibiotic, and evidence of epididymitis. On radiographic examination a rounded 4 cm. area of density was present in the upper portion of the right lung. A skin test with histoplasmin was positive, 4 plus. Tests for coccidioidomycosis, blastomycosis and tuberculosis (PPD) were negative.

A portion of lung measuring 3 x 2 x 4 cm. was removed. In the center was a firm, circumscribed nodule of yellowish-red mottling approximately 3 cm. in its greatest dimension. Examination of a frozen section revealed a combination of acute and granulomatous inflammatory reactions suggestive of a fungus infection. Permanent sections confirmed this impression. A relatively large artery coursed through the area and was involved by the reaction, with resultant occlusion and infarction. Organisms characteristic of *Histoplasma* were present in some areas of the nodule. These were well defined and easily seen in the Grocott modification of the Gomori silver methenamine stain¹, less easily in the Gridley stain, very indistinctly in a modified PAS stain, and could not be identified in the hematoxylin and eosin stains. The organism was later cultured from a portion of the specimen.

Case 2: This man was a 27 year old tobaccoconist who had worked in both North Carolina and Mexico in the previous year. Ten months before his admission to the hospital and two weeks before his symptoms began, he had cleaned a chicken coop in North Carolina. His first symptom was pleuritic pain in the lower right portion of the chest. Two months later, in Mexico, the pain returned, associated with a nonproductive cough. A few weeks later he was told he had a lung infection, and was treated with antibiotics. He returned to North Carolina and was treated again for pleuritis. There were decreased breath sounds at the base of the right lung, and roentgenograms showed effusion and a pleural reaction. A second strength PPD test was moderately positive, but the histoplasmin skin test was strongly positive.

Read before Section on Pathology, Medical Society of the State of North Carolina, Raleigh, May 10, 1960.

From the Department of Pathology, University of North Carolina School of Medicine, Chapel Hill.

Table 1
Disease Processes Found in 545 Surgical Specimens

Diagnosis	N. C. Memorial Hospital	N. C. Sanatorium	Total No. Cases
Tuberculosis	160	229†	389
Carcinoma	40	19	59
Bronchiectasis	22	11*	33
Benign tumor	3	3	6
Abscess	7*	5	12
Pneumonia	4	2	6
Bronchogenic cyst	4	3*	7
Pathogenic fungi	5	3	8
"Non-pathogenic" fungi	1	6	7
Nonspecific cavitation, scarring, cyst	6	6	12
Atypical acid-fast bacillus infection		3*	3
Miscellaneous	4	6	10
Totals	255	290	545

†Three specimens in this group also had "non-pathogenic" fungi.

*One specimen in each of these groups had "non-pathogenic" fungi.

Complement fixation tests for *Blastomyces*, *Coccidioidomyces* and *Histoplasma* were negative.

The right lung was decorticated and a nodule measuring 1½ cm. in diameter was removed from the superior segment of the lower lobe. The nodule was composed of spongy yellow-tan material surrounded by a white, firm capsule. The fibrous capsule surrounded an area of caseous necrosis containing oval bodies, best demonstrated by the silver methenamine stain, similar to those in the previous case. Cultures of the specimen were sterile.

Case 3: Although this 39 year old man had noted some increase in fatigability for the previous year, he did not seek medical advice until an area of increased density was found on his routine annual x-ray examination. Physical examination and laboratory data were not remarkable. Radiographic studies at North Carolina Memorial Hospital disclosed an area of increased density in the second right anterior interspace. Skin tests with histoplasmin, blastomycin, coccidioidin, and tuberculin were negative.

The superior segment of the lower lobe of the right lung was removed. It contained a granulomatous inflammatory reaction with numerous multinucleated giant cells and numerous small intracellular budding yeast forms. Studies with the silver methenamine stain indicate that they

are probably *Histoplasma* organisms.

Case 4: This 72 year old man was admitted to Gravelly Sanatorium approximately four months before his death. Fourteen months previously he had had a respiratory infection, for which he received antibiotics. However, for the past year he had had progressive dyspnea and weight loss (30 pounds). A month before his admission here, increased dyspnea, cough, anorexia and weakness developed, and he was admitted to another hospital. Examination revealed extensive cavitory disease in the left lung, interpreted as tuberculosis. He also had severe cardiac disease. Neither tubercle bacilli nor fungi were found in the sputum by smear and culture. Skin tests for *Blastomyces*, *Coccidioidomyces*, *Histoplasma* and tubercle bacilli (O.T., 1:1000) were negative. His condition upon admission to Gravelly Sanatorium, was essentially unchanged. The peripheral white blood cell count had risen from 9,800 to 17,500. Complement fixation tests for *Histoplasma* had a mycelial phase titer of 1:128 and a yeast phase titer of 1:256. During his hospitalization, the process spread from the left to the right lung. Repeated studies of sputum for fungi revealed only *Candida* species. Despite treatment with amphotericin-B, Gantrisin and Mycostatin, the disease progressed and the patient died.

Dense fibrous adhesions obliterated much of

Table 2
Types of Fungal Diseases

Diagnosis	N. C. Memorial Hospital	N. C. Sanatorium	Total No. Cases
Blastomycosis		1	1
Nocardiosis	1	1	2
Histoplasmosis	3		3
Actinomycosis	1	1	2
"Non-pathogenic" fungi	1	6	7
Totals	6	9	15

the pleural cavities. Small cavities and caseous tubercles were present in the left lung and the upper and middle lobes of the right lung. The upper lobe of the left lung had a 6 cm. cavity. Structures characteristic of *Histoplasma* were numerous in some areas. A *Candida*-like fungus was also present. In smears and tissue sections stained for acid-fast bacilli, such bacilli could not be found. Cultures of the lungs failed to grow either tubercle bacilli or fungi.

Our limited experience with histoplasmosis indicates the necessity of using the silver methenamine stain to find the characteristic organisms. In our material, the organisms stain so faintly with other methods that they may be easily overlooked.

B. *Nocardial* infections

Infection of the lungs by *Nocardia* organisms may result in a pneumonic type of lesion, abscess formation, or a combination of these processes.

The inflammatory reaction usually associated with infections by the *Nocardia asteroides* group is a combination of acute, chronic, and granulomatous reactions. Micro-abscesses of granulocytes are surrounded by a zone of macrophages, chronic inflammatory reaction, organizing pneumonia, or combinations of these.

One of these patients had a process that appeared by radiographic studies to be pneumonia but was a combination of pneumonia and small abscesses. Another patient had a large abscess.

Case 5: This 39 year old man was admitted to North Carolina Memorial Hospital one year before death because of fever, malaise, and a cough which had been present for two weeks. Physical examination was not remarkable.

The only significant abnormality revealed by laboratory studies was an elevated white blood cell count of 14,800. Cultures of the sputum did not produce pathogenic aerobic or anaerobic bacteria, fungi, or acid-fast bacilli. Roentgenograms of the chest showed an area of increased density in the right anterior second interspace and a rounded soft tissue mass in the right para-tracheal region. Skin tests for fungi and with PPD were negative, as were other extensive diagnostic procedures. Therefore, the upper lobe of the right lung was removed. The patient was then treated intensely with sulfonamides. Postoperatively, constrictive pericarditis developed, and required pericardectomy five months after the lobectomy. Four months later a bronchocutaneous fistula formed. His symptoms on his final admission

were related to intracranial metastasis. Autopsy showed no residual intrathoracic disease, but multiple cerebral abscesses due to a *Nocardia*.

The indurated posterior segment of the surgical specimen contained an abscess 9 mm. in diameter, with a firm white wall 1 to 2 mm. thick. The cavity contained soft, brown material. Another smaller abscess was present in the lateral aspect of the apical segment. The inflammatory reaction in some areas was acute, with micro-abscess formation, but varied to include areas of organizing pneumonia. The numerous small abscesses contained purulent material, and many multinucleated giant cells were in the walls. The organisms, seen best in tissue sections with the Brown-Brenn stain², were cultured from the specimen and proved to be *Nocardia asteroides*.

Case 6: This 46 year old man had had a productive cough for four weeks before admission to the North Carolina Sanatorium, McCain, North Carolina, and had lost approximately 20 pounds. He had coughed up approximately one-half cup of bright red blood two weeks before admission. Physical examination was not remarkable. His white blood cell count was 13,500, with 67 per cent granulocytes. Radiographic examination revealed a density suggestive of an abscess in the upper lobe of the right lung. The density did not change after two months of chemotherapy, and the posterior segment of the upper lobe was removed.

The specimen contained an abscess measuring 1.5 x 1.5 x 0.5 cm. It had a granular reddish-brown lining and was without a definite wall. The adjacent lung was firm and greyish. Microscopic study revealed changes ranging from acute inflammatory reaction to a chronic organizing pneumonia. The cavity was lined by granulation tissue and contained purulent exudate. Gram-positive filamentous elements similar to *Nocardia asteroides* were present in some areas of the exudate. The organism was not isolated from cultures of the sputum and specimen.

Our experience with nocardiosis indicates that this organism should be searched for wherever the peculiar combination of micro-abscesses and chronic or granulomatous inflammation exists and when other more easily identifiable fungi such as *Actinomyces* or *Blastomyces* cannot be demonstrated. We prefer the Brown-Brenn bacterial stain to any of the other stains for demonstration of the thread-like, gram-positive filaments in the tissue sections.

C. *Unidentified* fungi

Masses of fungi such as *Aspergillus*, *Candida*, and *Penicillium* are sometimes found in lung tissues in varying relation-

ships from incidental saprophytic states through minimally invasive to fulminating infections. Infections by these organisms may be associated with malformations such as bronchogenic cysts, with other previous or present infections such as lung abscesses, tuberculous and bronchiectatic cavities, with bronchogenic tumors, or with debilitated states resulting from such causes as distant tumors, leukemias, and lymphomas. These infections appear to be increasing in frequency with the use of antibiotics and steroids. The presence of these organisms is often not suspected, and hence the cultures necessary for definitive diagnoses are too seldom made. An *Aspergillus* was isolated from the sputum of one of our patients before operation. None of the six specimens in this group were successfully cultured for fungi. We prefer, therefore, not to assign these to a specific group, although others have called somewhat similar cases "Aspergillosis."

The masses of fungi in all of the specimens, including that from the patient whose sputum contained an *Aspergillus* species before operation, had a similar appearance in the tissue sections. The hyphae were of fairly uniform diameter (3 to 4.5 micra) and relatively straight. Septations were common (6 to 15 micra) and Y type branchings were frequent. Occasional cells were wider than the others, faintly yellow-brown, and in some instances gave rise to nonseptate structures wider than the usual hyphae. Occasional small yellow-brown spherules or ovals (2 to 3 micra in diameter) suggestive of spores were present in all cases except No. 12. In case 10, yellow-brown conidiophores with a few sterigmata were occasionally present. This latter observation indicates that the organism in this case was probably an *Aspergillus*.

Large masses of hyphae in the cavities often had a peripheral rim of widened acidophilic hyphae (6 to 12 micra). Amorphous paler acidophilic material was present between these hyphae, and occasional hyphae had a central core of somewhat similar material. The appearance resembled the familiar "clubbing" at the periphery of actinomycotic sulfur granules. Yeast forms

were not present in any of the material studied.

In case 8 hyphae were in the wall of the cavities. In case 12 the hyphae extended into the adjacent tissue.

Tuberculosis and Fungi Infection

Case 7: This 55 year old man was found to have pulmonary changes suggestive of tuberculosis on a chest roentgenogram four years before he was hospitalized. He related that he had only a slight cough and blood-streaked sputum with "colds." X-ray films of the chest showed changes indicative of fibrosis at the right apex and a dense area in the left upper lung field with radiolucent areas suggestive of cavities. Smears and cultures of sputum were negative for acid-fast bacilli and fungi. The second strength PPD gave a 1 plus reaction. The apical-posterior and anterior segments of the upper lobe of the left lung were removed.

The specimen contained subpleural cavities measuring up to 1.5 cm. in diameter, with smooth grey walls less than 1 mm. thick. Small irregular areas of scar tissue and tubercles 1-3 mm. in size were also present. Some of the small cavities contained necrotic cellular debris. Within the debris in some cavities small masses of fungi were present. Extensive granulomatous inflammation with noncaseous tubercles and scarring were present in the remaining parenchyma. Acid-fast bacilli were not present in smears of the tubercles nor were they cultured from the specimen.

Case 8: This 15 year old girl had symptoms of a respiratory infection for three months before she was admitted to the North Carolina Sanatorium. An x-ray film of the chest showed mottling of the right lung field and a 5 cm. cavity in the upper lobe. Changes suggestive of cavity formation were present in the left lung field. Acid-fast organisms were present in a smear of the sputum, and tubercle bacilli were cultured from the sputum. After four and one-half months of chemotherapy, the upper lobe of the right lung was removed because of the large cavity.

Two cavities were present in the lobe. They measured 4 x 5 cm. and 2.5 x 2 cm. respectively, and communicated with segmental bronchi. Both cavities had relatively smooth grey walls, but the smaller contained granular yellow-white debris. Masses of hyphae were present within both cavities. Hyphae were also present in the superficial portions of the walls.

Lung Abscess with Fungus

Case 9: A 47 year old man, had had ankylosing spondylitis with a fixed rib cage for 29 years, diabetes mellitus for six years, and increasingly

evere cough for five years. Radiographic examination showed a cavity in the left upper lung field. The cavity appeared to contain inspissated debris and a mycetoma. A second strength PPD test was negative. One sputum culture grew out *Aspergillus* preoperatively. The upper lobe of the left lung was removed.

The cavity was in the apical posterior segment and extended into the anterior segment. Its greatest diameter was 8 cm. It was lined by reddish-brown material and contained large masses of soft greyish-brown material. The apical-posterior segmental bronchus communicated with the cavity. An area of consolidation was present in the anterior and lingular segments. The masses in the cavity consisted of mycelia. About the cavity were areas of chronic organizing bronchopneumonia and occasional small non-caseous tubercles.

Fungus in a Bronchogenic Cyst

Case 10: A 49 year old woman had been well until four days before her admission, when she had hemoptyses so massive that three units of blood were used for transfusion. Physical examination and radiographic examination at the North Carolina Sanatorium revealed a cyst-like structure in the mid-portion of the right lung. Examination of sputum revealed only a hemolytic *Staphylococcus* and *Streptococcus viridans*. The lower lobe of the right lung was removed; it contained a large cystic structure (4 x 4 cm.) which communicated with the lateral basal segmental bronchus. The cyst was lined by respiratory epithelium and contained bundles of smooth muscle in its fibrous wall, indicating that it was probably a bronchogenic cyst. The cyst contained a small ball of mycelia.

Fungus in a Bronchiectatic Abscess

Case 11: This 56 year old woman was admitted to North Carolina Sanatorium because of repeated small hemoptyses. Physical examination revealed a marked scoliosis, limited expansion of the left side of the chest, dullness to percussion, and fine crepitant rales on the left side. Radiographic studies demonstrated opacity of most of the left lung field, and marked bronchiectasis on the left, with relatively normal bronchi on the right. Smears and cultures of sputum and gastric washings did not reveal tubercle bacilli.

The left lung was removed. The two lobes were fused by scar. The bronchi were ectatic. A cavity, 10 x 4 x 3 cm., extended from the upper to the lower lobe through the adherent area. Several small bronchi communicated with the cavity, which was lined by respiratory and squamous epithelium, and contained purulent debris and masses of hyphae. Similar masses were also present in some of the smaller bronchi. Areas of scarring were present throughout the remainder of the lung.

Atypical Acid-fast Bacillus Infection

Within recent years acid-fast bacilli, differing from the tubercle bacillus in several respects, have been found associated with granulomatous changes, including cavity formation, which cannot be distinguished anatomically from those caused by the tubercle bacillus. In some patients these atypical bacilli have been found in association with *Mycobacterium tuberculosis*—at times concomitantly and at other times only when the patient's sputum no longer contained the tubercle bacillus. In other patients, no association with tubercle bacilli has ever been demonstrated and the atypical acid-fast bacilli appear to be the causative agents of the anatomic changes. These bacilli can usually be distinguished from the tubercle bacilli by their sometimes rapid growth in culture, by the presence or absence of pigment in colonies when grown either in light or in darkness, by high catalase activity, or by combinations of these characteristics. The bacilli are sometimes longer and wider than the tubercle bacillus. Other strains are shorter and more coccoid. Still other strains have a morphologic appearance similar to the tubercle bacillus. Beading is sometimes very striking.

These organisms are not pathogenic for the guinea pig, although they are for other laboratory animals. They are resistant to the effects of many presently used antituberculous drugs, and therefore their detection is of considerable importance. The practice of making a definite diagnosis of tuberculosis on the basis of tubercle formation or caseous changes and the presence of acid-fast bacilli should be discontinued. The diagnosis of tuberculosis should be based upon recovery of an organism having the cultural characteristics of the tubercle bacillus.

Case 12: This 54 year old man had symptoms of slight pain in the right side of the chest and a productive cough for three months before his admission to North Carolina Sanatorium. Physical examination was not remarkable. Radiographic examination revealed a cavity in the right lung with some smaller densities in the adjacent lung. Acid-fast bacilli were present in his sputum on admission, and cultures of his sputum contained atypical acid-fast bacilli.

The apical and posterior segments of the upper lobe of the right lung were removed after five months of chemotherapy, principally streptomycin, to which the organism was somewhat sensitive.

The lobe contained tubercles varying in size from 2 to 7 mm. The gross and histologic changes were indistinguishable from those caused by the tubercle bacillus. The bacilli were longer and wider than the typical tubercle bacilli. In one area was a mass of mycelia, some of which extended into the walls of an adjacent bronchiole.

Yeast forms were not present. The fungus was not recovered by culture.

Case 13: The patient, a 43 year old woman, had severe chest pain and dyspnea three months before admission to the North Carolina Sanatorium in July, 1957. A density in the upper portion of the left lung remained unchanged despite antibiotic therapy. A productive cough developed. Smears and cultures of sputum did not contain acid-fast bacilli. The apical-posterior segment of the upper lobe of the left lung was removed when the lesion failed to change after a month of treatment with isoniazid and para-aminosalicylic acid.

The segment contained a cavity measuring 2 x 1.5 x 1.5 cm., which was lined by caseous material. Several caseous tubercles, up to 0.4 cm. in diameter, were present in the adjacent parenchyma. Smears of the wall of the cavity contained acid-fast bacilli which were longer and wider than the tubercle bacillus. Photochromogenic organisms were obtained upon culturing the resected lung tissue.

Case 14: A 24 year old man was found to have a cavity in the apex of his right lung three and one-half years before his admission to the North Carolina Sanatorium. Nine months after this discovery, the apical and posterior segments of the upper lobe of the right lung were resected in the VA Hospital, Oteen, North Carolina. He had done well following the operation until extension of the pulmonary lesions occurred shortly before his admission to the North Carolina Sanatorium. He had no physical abnormalities except a right thoracotomy scar. Sputum cultures made at North Carolina Sanatorium contained atypical photochromogenic organisms which showed partial resistance to streptomycin, isoniazid and kanamycin. A year after his admission there, the remaining portion of the upper lobe was resected. Culture of the surgical specimen revealed an atypical photochromogenic organism which was thicker than typical tubercle bacilli.

The segment contained a 2.5 x 3.5 cm. cavity lined by yellow-brown material. The surrounding parenchyma was scarred. Endobronchial tubercles were present in a communicating bronchus. Acid-fast bacilli were present in a smear of the cavity's contents. The anatomic changes could not be differentiated from those caused by the tubercle bacillus.

Lipid Pneumonia

Some years ago lipid pneumonia was more common than at present. This fact is probably related to decreased use of lipid solutions in proprietary drugs and more intelligent use of drugs still being made with such materials.

The changes of lipid pneumonia sometimes cannot be distinguished radiologically from those associated with tumors or infections. Anatomic differentiation from tuberculosis or some of the mycoses may sometimes be difficult.

Case 15: The patient in this group was a 33 year old woman who was found on routine examination to have an area of density in the right lung. When the density remained unchanged during a period of observation at the North Carolina Sanatorium, the segment of lung containing the area was removed.

The tissue contained multiple firm, white areas varying in size from 0.3 to 1.5 cm. Some had soft centers. The microscopic pattern was of irregular scarring of the lung, with numerous lipid-laden macrophages. The lipid material stained orange with Sudan IV, as mineral oil does.

Upon further questioning the patient related that she had been taking mineral oil every night for many years, and that she usually slept in a prone position.

Sequestered Lung

As the number of pulmonary resections has increased in the past several years, there has been an increasing number of reports of an unusual malformation—that of an artery rising from the aorta, rather than the pulmonary artery, supplying a portion of a lobe of a lung. These patients generally have an inflammatory reaction in that portion of the lobe with the anomalous blood supply. An abscess or bronchogenic cyst is often present. Occasionally the patients seek help because of hemoptyses, which may be slight or massive. Occasionally they have no symptoms, and the inflammatory or cystic changes are found on incidental radiographic examination.

Case 16: This 33 year old woman was admitted for study because of an asymptomatic density in the lower portion of the right lung discovered during a routine examination. The lower lobe of the right lung was removed. Very large anomalous vessels supplied portions of the lobe. These vessels penetrated the diaphragm, and were thought to originate from the abdominal aorta and inferior vena cava. Communications of these vessels with pulmonary vessels could not be demonstrated. A large cavity (5 x 3 x 2 cm.) was in the medial and posterior basal segments. It contained necrotic purulent exudate. It was lined largely by respiratory epithelium, with small areas of ulceration. Cartilage, occasional small bundles of smooth muscle, and islands of bronchial mucus glands were present in its wall, indicating the probability of its being a bronchogenic cyst. Bronchial arteries present had endarteritic changes. The large vessels had the structure of large systemic elastic arteries, and their branches, the structure of systemic muscular arteries. The adjacent lung was emphysematous. Bundles of hypertrophied smooth muscle were in the walls of bronchioles and alveolar ducts in some areas of the adjacent tissue.

Summary

A total of 545 surgical specimens of lung issues have been examined in three and one-half years. These include 3 cases of histoplasmosis, two cases of nocardiosis, 6 cases of unidentified fungi associated with other pulmonary diseases, 2 cases of actinomycosis, 1 case of blastomycosis, 3 cases of infection by atypical acid-fast bacilli, 1 case of lipid pneumonia, and 1 case of so-called sequestered lung.

The patients had varied nonspecific histories, symptoms, signs, and radiologic and laboratory data, indicating that patients with similar symptoms and signs may have diseases caused by quite dissimilar agents.

Anatomic studies can be helpful in directing bacteriologic studies, which should be the basis for definitive diagnoses. The

Brown-Brenn stain and the Grocott modification of the Gomori silver methenamine stain are most helpful in the search for fungi.

The diagnosis of tuberculosis should be based on the cultural characteristics of the causative agents, and not upon the morphologic appearance of the tissue reaction nor the presence of acid-fast bacilli alone.

The authors are indebted for clinical, radiologic, and bacteriologic data to the staffs of North Carolina Memorial Hospital and Gravelly Sanatorium, Chapel Hill, and North Carolina Sanatorium, McCain, and especially to Dr. William H. Gentry, Medical Director, North Carolina Sanatorium, who was most generous and cooperative in furnishing us with the data.

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Cardiac Disorders in Infants

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The diagnosis of cardiac disorders in infants is difficult for several reasons. First is the infant's size and inability to cooperate. Second, many of the congenital malformations of the heart, and even some of the acquired disorders such as idiopathic myocarditis, are severe lesions and often are associated with congestive heart failure and a precarious state. In the presence of congestive heart failure, the circulatory dynamic aspects of this disorder obscure the initial basic disease. Third, the infant, particularly the newborn baby, is undergoing a transitional circulatory phase wherein his right ventricle is performing more work relative to the left than is the case later in life. Criteria for the diagnosis of cardiac conditions in the older child cannot always be extrapolated to the infant state.

Because of these difficulties, diagnostic

methods other than the time-honored use of auscultation and standard x-ray techniques are being developed. The purpose of this paper is to discuss briefly a number of the new methods that have been found to be most specific and helpful in the diagnosis of cardiac diseases.

Discussion of the Methods

1. *Electrocardiography*: The electrocardiogram has proved to be far more effective in distinguishing congenital malformations of the heart than was expected. In particular, it shows enlargement of the ventricular chamber and can even suggest whether the enlargement is caused by increased blood flow or an obstruction. Also, highly valuable information concerning atrial hypertrophy can be obtained.

Although electrocardiograms are difficult to obtain on premature infants, a chest lead cummerbund has proved successful with newborn infants. Two major limitations of electrocardiography in the infant are that

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the right ventricular preponderance normally present may obscure abnormal right ventricular hypertrophy, and that the electrogram only reveals enlargement of the chamber without in any way describing specific lesions.

2. *Phonocardiography*: The phonocardiogram has also proved to be an extremely important new diagnostic method, as well as being an effective device for teaching auscultation and checking auscultatory findings. Methods principally developed by Leatham¹ in England and McKusick² in the United States have been perfected to the point that the phonocardiogram will often show a rather specific tracing for a particular type of congenital disorder of the heart. Thus the phonocardiograms of infants with ventricular septal defects, patent ductus arteriosus, aortic stenosis, or tetralogy of Fallot, for example, will be nearly diagnostic. The phonocardiogram can also be used on newborn infants where auscultation is particularly difficult because of the tachycardia.

3. *Cardiac catheterization*: Catheterization of the right side of the heart can be performed on newborn infants by a saphenous vein approach, when approach through the antecubital vein is impractical. Satisfactory pressures and samples can be obtained through a no. 4 or no. 5 catheter. We have found two major limitations to this method. First, it is technically difficult to manipulate a catheter from the saphenous vein approach in such a way that the tip will enter the pulmonary artery of the young infant. Incomplete studies can be done, however, and sampling from the right ventricle, right atrium, and venae cavae is not difficult. Secondly, the risk of inducing ventricular fibrillation during catheterization is far greater in infants than in older children. The very appreciable mortality rate of 1.7 per cent quoted by Ziegler³ for infants younger than 18 months of age may be improved by having available an external defibrillator⁴. After 18 months of age the mortality rate drops considerably and the procedure can be considered quite safe.

Catheterization of the left side of the heart has been accomplished by several procedures. For the infant, the most effective

method has been to introduce the catheter in a retrograde fashion up the right brachial artery into the aortic arch and down through the aortic valve. Vlad and Lambert⁵ have been able to catheterize the left ventricle even in cases of aortic stenosis. The left side of the heart appears to tolerate catheterization about as well as the right. Simultaneous pressure curves from the right and left sides can give information of considerable value, especially in those conditions where two-way shunting of blood is present.

Another method of catheterizing the left side of the heart in children is that introduced by Braunwald⁶. It consists of introducing a firm catheter into the right auricle by way of the saphenous vein. This catheter is pressed against the inner atrial septum, after which a sharp hollow trocar is pushed through it until the wall of the atrial septum is pierced. Next a plastic catheter may be introduced through the trocar and into the left atrium and left ventricle. This procedure, which has been successfully applied to adults and older children, is obviously not without risk, and at present the catheter is too large for use in the newborn infant. Direct needling of the left ventricle lumen through the anterior wall of the chest at the apex provides information about the pressure that is particularly valuable in cases of aortic stenosis. Angiocardiograms have been performed by direct left ventricular injection.

4. *Dye dilution methods*: Injection of dye into one part of the circulation with collection from a site downstream has been used by Wood⁷ and others to obtain indicator dilution curves for different malformations. For example, if Cardiogreen dye is injected into the right atrium of a child with tetralogy of Fallot and collection is made in the femoral artery, a curve showing two humps will appear. The initial hump will represent dye that has mixed with blood passing from the right ventricle to the left ventricle and aorta through the ventricular septal defect. The second hump will result from the normal circulation of blood. From the curves obtained, an index of the amount of shunting can be estimated.

5. *Injection of Krypton 85 solution:* Radioactive Krypton 86 is a material which is very rapidly excreted by the lungs. In fact, when Krypton solution is injected into the right side of the heart, 95 per cent of the solution will be cleared during one passage through the pulmonary circulation. Thus, if Krypton 85 is injected into a right auricle and collection for analysis is made from the aorta, normally almost all of this material will be eliminated by the lungs and the arterial collection will show a very low value. If, however, a right-to-left shunt exists, such as in tetralogy of Fallot, and the material is injected proximal to the shunt—for example, in the right atrium—not all the material will be eliminated by the lungs; some will be carried through the ventricular septal defect to the sampling site in aorta, and a high count of radioactivity will be observed.

Similarly, Krypton 85 can be shown to demonstrate small intracardiac shunts from left to right. When the material is injected into the left side of the heart and the radioactivity of expired air is sampled, if the circulation is normal this radioactivity will not rise until the normal time for blood to circulate from the left side of the heart through the peripheral capillaries back to the right side and to the lungs. If a left-to-right shunt exists, however, the radioactive Krypton will be carried through the shunt to the right circulation and then out to the lungs, and will be picked up early in the expired air as radioactive gas. Braunwald⁸ has found that this method is quite good in demonstrating very small shunts which would not be detected by cardiac catheterization, and that it is applicable to the young infant.

4. *Nitrous oxide gas inhalation:* Another method that has been used for showing small left to right shunts is the use of nitrous oxide gas during cardiac catheterization on the right. If a normal patient breathes nitrous oxide, it will be absorbed into the pulmonary capillary blood and will pass to the left side of the heart and then to the peripheral circulation. The amount of nitrous oxide returning to the right side of the heart will be small and will appear late.

On the other hand, if the patient has a small left-to-right shunt—for example, a ventricular septal defect—inhalation of nitrous oxide gas will result in saturating the blood in the left side of the heart with this material, which will pass through the ventricular septal defect and be detectable early, in large concentration, by a catheter placed in the right ventricle or pulmonary artery. Morrow⁹ has shown that shunts can be localized—for example ventricular septal defect, atrial septal defects, or ductuses—with considerable accuracy, and that it is more sensitive than standard cardiac catheterization in revealing small shunts.

7. *Intravascular potentiometric electrodes:* Barger and Clark¹⁰ have recorded potentials when hydrogen gas or sodium ascorbate contacts a platinum electrode placed in the blood stream. The potential produced is a function of the concentration of hydrogen gas or ascorbate, and the concentration curve is similar to that of a dye solution. This method perhaps is more promising than any of the similar techniques noted above, because of its safety and simplicity.

8. *Angiocardiography:* Since its introduction by Dotter and Steinberg¹¹, there has been a marked refinement in the instrumentation for angiocardiography. In this diagnostic technique, radio-opaque material, usually complex iodine compound, is introduced into the blood stream through a catheter, either by way of a peripheral venous site, peripheral arterial site, or central site. Serial x-ray films showing the passage of a radio-opaque dye from chamber to chamber are then obtained. The most commonly used angiocardiographic apparatus now is (1) the Schonander film changer, which takes 6 films per second in a single plane, or may take films at right angles; and (2) cine-angiographic equipment where an image intensifier brightens the fluoroscopic image so that motion pictures can be taken of it.

Along with the improvement in the technology of serial roentgenograms, there have been striking improvements in the injection materials. Whereas injection with Urokon and Diodrast was a procedure perhaps as dangerous as cardiac catheterization, use of the new materials, Hypaque, Renograffin

and Cardiograffin, appears to be relatively safe. From our experience of more than 100 studies of infants, no serious reactions have occurred with the use of the new injection agents, and in fact no more threatening events than several episodes of transient bradycardia. It would thus seem that if the diagnostic information is to be obtained by either angiocardiology or cardiac catheterization, angiocardiology is the safer method.

Conclusion

With the variety of methods of study available for diagnosing cardiac disorders in infants, an approach may be patterned to fit the particular case.

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Medicine is a pragmatic discipline, not a doctrinal one. We use a drug not because it is "good" or "just" or "honorable," but because it is effective. When a new drug comes along which is more effective, we will abandon the old one. In medicine, the end-result justifies the means. Evaluation of the end-result is of necessity a . . . statistical process, whether formal or informal, deliberate or subconscious. If patients could not be classified into groups and if a generalization based on experience with a group could not be applied to an individual, how would we know when to perform an appendectomy in an individual patient, when to administer a drug, or how to make a prognosis.—Editorial: Statistics Are All Very Well, But . . . : New York State J. Med. 60: 3598 (November 15) 1960.

Continuous Caudal Analgesia in Private Practice

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Continuous caudal analgesia is not a new technique. It was introduced in 1942 by Hingson and Edwards, and enjoyed widespread popularity in the early postwar years. The initial enthusiasm waned, however, and today it is used sporadically by many obstetricians, but routinely by only a few. The objections most frequently voiced by those who do not use the method are: (1) technical difficulties associated with frequent failures; (2) frequent hypotension; (3) the desire of patients to be asleep; (4) the increase in operative deliveries; (5) the requirement of constant attendance by specially trained personnel. The last mentioned is the reason most frequently given for not using caudal analgesia in private practice.

We have used caudal analgesia routinely for labor and delivery for more than six years, and one of us (R. J. R.) for some 13 years¹. Raleigh is one of the few remaining strongholds of the method. Of the 10 specialists here, seven use it routinely, and one uses its counterpart, epidural analgesia. It has been highly satisfactory, and is as popular with the women of Raleigh as it is with the obstetricians.

Because the criticisms listed above have not seemed altogether valid, we believed that a critical examination of the method as we use it was in order. This review is not a controlled study comparing caudal analgesia with other forms of anesthesia. It is rather a presentation of one year's experience with the method in an effort to determine its effectiveness, its safety, and, above all, its practical application in a busy obstetric practice.

Materials and Method

All private deliveries which we performed in the year 1958 were reviewed. As seen in

Table 1

Types of Anesthesia Used for Delivery (1958)	
Continuous caudal	371
Saddle block	16
General (inhalation)	9
Pudendal block	3
"Natural childbirth"	1
Cesarean sections	13
Total	413

table 1, there was a total of 413 deliveries, 371 of which were conducted under continuous caudal analgesia. Three patients had hypnosis, but since all 3 received supplementary caudal analgesia toward the end of labor, they are included in the caudal group. The cesarean sections were, for the most part, done under spinal or local infiltration supplemented by intravenous Pentothal.

Of the patients receiving caudal analgesia, 154 were primigravidas and 217 were multigravidas. Labor was induced electively in 22 patients, all multigravidas.

Technique

The technique used is essentially that described in Lull's and Hingson's classic textbook, *Control of Pain in Childbirth*². We use the catheter technique³ employing a 16-gauge Love-Barker spinal needle and a polyethylene catheter with a lumen large enough to accommodate a 22-gauge needle. The patient is given 1.5 to 3 grains (100-200 mg.) of pentobarbital or its equivalent on admission to the hospital in labor. The caudal catheter is inserted soon after arrival in the labor suite, and the membranes are ruptured artificially at the same time. The latter is not done in cases of breech presentation or when the vertex is not well engaged. The analgesia is usually started after labor has been well established and cervical dilatation has reached about 3 cm. in multiparas and 4 to 5 cm. in primigravidas. The anesthetic agent used was a 1.5 per cent solution of Metycaine.

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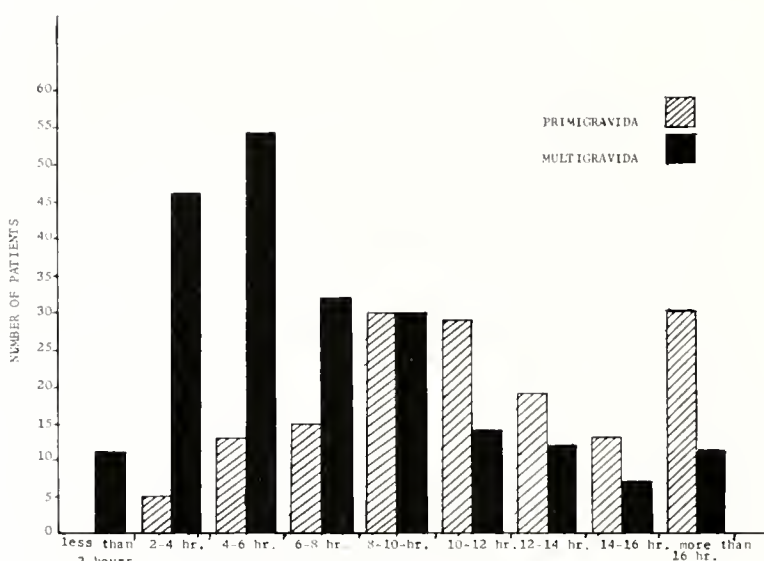


Fig. 1. Length of labor (371 cases).

Effects on Labor and Delivery

As shown in figure 1, most of the multigravidas were delivered in less than 6 hours and the primigravidas on an average of between 8 and 12 hours. These averages are somewhat less than the 8 and 14 hours respectively quoted in Eastman's textbook⁴.

Figure 2 shows the duration of caudal analgesia from the initial injection of the test dose until delivery. The anesthetic effect usually lasted from 30 minutes to an hour after delivery, easily enough time to allow unhurried repair of the episiotomy. The average duration for all cases was about three hours, with the great majority of the multigravidas requiring analgesia for less than two hours prior to delivery.

Conduction anesthesia of all kinds frequently shortens labor by relaxing the soft tissue resistance of the birth canal. Labor can be slowed, however, if the level of nerve block is allowed to go above the desired eleventh thoracic vertebra. As seen in table 2, this occurred in about 13 per cent of the cases in this series. Many of these patients required only a short time for the level to drop. Then good labor was restored. Others received small doses of oxytocin in a dilution of 1:10, and 7 required oxytocin by infusion. This has not been a major problem.

Caudal analgesia reportedly causes a great increase in occiput posterior presentation and in transverse arrest. In this series, these malpresentations occurred in only about 11 per cent of the cases. As a general rule, rotation was much easier than under general anesthesia because of the great relaxation of the soft tissues. More than half required only manual rotation.

Table 4 shows the types of delivery performed in this series under caudal analgesia. The equal incidence of spontaneous and low-forceps deliveries is of no significance other than to illustrate the point that more than 80 per cent were easy deliveries. The 15 per cent incidence of mid-forceps deliveries is admittedly high, but not unexpected. Under caudal analgesia the abdomino-perineal

Table 2
Effects on Progress of Labor

	No. Cases	Per Cent
Not slowed	324	87.3
Slowed by caudal analgesia		
Slight, required no stimulation	13	3.5
Require fractional Pitocin	27	7.3
Required Pitocin infusion	7	1.9
	47	12.7
Total	371	100.0

Table 3
Presentations at Time of Delivery

	No. Cases	Per Cent
Occiput anterior	318	85.7
Occiput posterior	23	6.2
(a) Required manual rotation	11	2.9
(b) Required forceps rotation	12	3.2
Transverse arrest	16	4.3
(a) Required manual rotation	10	2.7
(b) Required forceps rotation	6	1.6
Breech	12	3.2
Other (one brow and one set twins)	2	0.5
Total	371	

Table 4
Types of Delivery

	No. Cases	Per Cent
Spontaneous	151	40.7
Low forceps	151	40.7
Mid-forceps	57	15.4
Breech	12	3.2
Spontaneous with assistance	7	1.9
Decomposition and extraction	5	1.3
Total	371	100.0

reflex is abolished and the patient's ability to push in the second stage is greatly reduced. We generally allow at least one hour (more often two) after full dilatation to see if the patient can push the presenting part to the perineum. If no appreciable progress is made in that time, however, mid-forceps

delivery is resorted to without qualms. The great majority of these deliveries would be classified by Dennen⁵ as "low-mid," since the head was not quite on the perineum. As with the operative rotations mentioned earlier, the mid-forceps deliveries were generally easier than under general anesthesia.

It should be noted that 12 breech presentations were delivered under caudal analgesia. Some doctors consider a breech presentation a contraindication to spinal and caudal anesthesia. We agree with Nicodemus⁶ that caudal is the preferable method of analgesia for a breech presentation. In cases where decomposition and extraction is to be used, however, an anesthetist should be present and ready to give immediate general anesthesia in the event of a constriction ring in the irritable uterus.

Table 5
Effectiveness and Side Effects

	No. Cases	Per Cent
Good relief	359	96.8
Partial relief	10	2.7
No relief (complete failure)	2	0.5

Table 5 shows that nearly 97 per cent of the patients experienced good relief. The 10 cases of partial relief may have been due to a unilateral effect—perineal relief only, or, rarely, abdominal relief with perineal failure. It can only be assumed that the catheter was not quite properly placed, or that some form of sacral anomaly was present in these cases.

That there were only two complete failures deserves comment. When caudal analgesia was first introduced, it was popularly believed that only about 80 per cent of

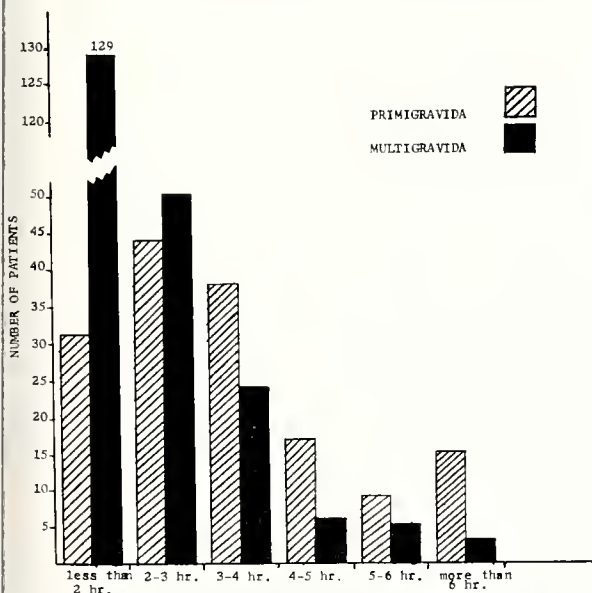


Fig. 2. Length of caudal analgesia (371 cases).

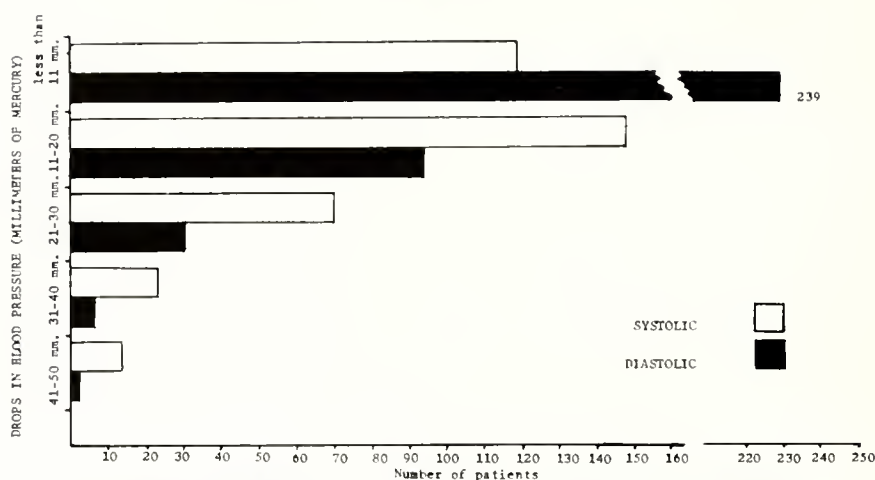


Fig. 3. Decrease of blood pressure during caudal analgesia.

women were candidates, the others being excluded by sacral anomalies, neurologic, psychologic or circulatory defects, and so forth. Continued experience has tended to convince us that almost any woman can be given caudal analgesia with good hope of success. In places where the method is not well known, a reassuring explanation is, of course, in order.

So-called "pressure pains" are frequent enough to be annoying (18.0 per cent of the cases). They consist of a sense of discomfort across the lower pelvic region or groin with each contraction late in the first stage or just prior to delivery. Pain is apparently due to pressure of the fetal head on the pubic rami, and it seems to occur most frequently when the infant is large. Light Trilene inhalations are occasionally necessary in the more severe cases.

The term "shakes" is unscientific but descriptive of the uncontrolled shaking that nearly 20 per cent of the patients exhibited. This phenomenon closely resembles a febrile chill, but the patient does not complain of feeling cold. It is due to an "overdose" of Metycaine, with absorption of the agent into the circulation faster than the liver can detoxify it. The effect is temporary, and there were no sequelae in this series.

Effects on the Mother

The most frequent effect on the mother, other than the excellent analgesia and muscle relaxation, is a drop in blood pressure.

This potential hazard is not to be minimized, and is one of the reasons that constant attention to the patient under caudal analgesia is mandatory.

As can be seen in figure 3, the average drop in the systolic pressure is about 20 mm. of mercury and in the diastolic about 10 mm. This hypotension is due to splanchnic pooling of blood in the lower portion of the body owing to the vasomotor block by the conduction anesthesia. It does not constitute a state of shock, the pulse remains strong and slow, and the patient does not become clammy or apprehensive.

As the table shows, only a very few patients had alarming falls in blood pressure. The milder cases of hypotension were easily controlled by turning the patient on her side, thereby removing the weight of the gravid uterus from the vena cava. This simple maneuver usually increased the pressure by 10 mm. or more. If the pressure fell below 90/60, oxygen inhalations were routinely given. If the fall was to a level of 80/50 or below, 25 mg. of ephedrine was given intramuscularly. This measure was necessary only eight times in this series. Fetal anoxia due to maternal hypotension can occur but has been extremely rare in our experience and was not encountered at all in this study.

Caudal analgesia produces essentially no other undesirable effects on the mother. We have not yet encountered a drug reaction, infection, or any permanent neurologic

Table 6**Side Effects of Caudal Analgesia**

	<i>No. Cases</i>	<i>Per Cent</i>
Pressure pains	67	18.0
"Shakes"	73	19.4

sequelae. There are no headaches such as occur with spinal anesthesia.

Effects on the Infant

The relative safety of the fetus with all forms of local or conduction anesthesia as compared to general anesthesia is well known. Caudal analgesia has no depressing effect on the fetus provided the maternal hypotension is controlled. Indeed, since little or no sedation is needed during the last few hours of labor, most of the infants are born pink and crying.

Table 7**Condition of Infant at Birth**

	<i>No. Cases</i>	<i>Per Cent</i>
Good	354	95.4
Slightly depressed	11	2.9
Very depressed	4	1.1
Stillborn (both macerated)	2	0.5
Total	371	100.0

As seen in table 7, more than 95 per cent of the infants in this series cried spontaneously in the first minute after delivery. Eleven required a slightly longer time before crying, but only 4 required active resuscitative measures. One of these had the cord wound tightly around the neck twice; the second was erythroblastotic; another was post-mature; the fourth had multiple congenital anomalies of which it later died. There was one other neonatal death—due to hyalin membrane. Both the stillborn infants were known to have been dead for some time. Caudal analgesia was still the choice for these mothers for the relief it afforded in labor. Both, however, were given supplementary light nitrous oxide—oxygen anesthesia for delivery in order to avoid psychic trauma.

Patient's Acceptance

The ideal obstetric anesthetic must be not only effective and safe but also acceptable to the patient. This is particularly true in private practice. Table 8 shows that more

Table 8**Patients' Reaction to Caudal Analgesia**

	<i>Yes</i>	<i>No</i>
Completely satisfied	354 (95.4%)	17 (4.6%)
Would request caudal again	358 (96.5%)	13 (3.5%)

Table 9**Comparison with Previous Anesthesia (133 cases)**

	<i>No. Cases</i>	<i>Per Cent</i>
Preferred caudal	126	94.7
Preferred other	7	5.3
Total	133	100.0

than 95 per cent of the patients were completely satisfied with caudal analgesia and would request it again. The great majority of the patients who had had pressure pains and "shakes" (table 6) still placed themselves in the "completely satisfied" group, thus confirming the opinion that these side effects did not offset the analgesic effectiveness.

Of the 133 multigravidas who had had some other form of anesthesia, usually general, for a previous delivery, 94.7 per cent preferred caudal. It is rare indeed for a patient who has been awake for one delivery to want to be put to sleep for another one.

Comment

The foregoing statistical review has demonstrated that continuous caudal analgesia is effective and safe. What other methods of anesthesia can offer good results in 97 per cent of the cases (table 5)? There have been no maternal deaths and no neurologic sequelae in this series nor in our more than 13 years' experience with the procedure. The number of newborn infants to cry spontaneously within one minute (95.4 per cent) would certainly compare favorably with most other forms of obstetric anesthesia.

The study has also illustrated some of the potential hazards of the method, such as hypotension, pressure pains, "shakes," and occasional slowing of labor. These conditions are easily controlled by competent and constant attention to the patient for the entire duration of continuous analgesia. This of course raises the question of its practical application as a routine procedure in private practice.

We readily admit that we could not afford to use caudal analgesia if we ourselves had to sit with patients throughout labor. For this reason the labor nurse system has become well established in Raleigh. Each obstetrician has one or two registered nurses working for him or, in most cases, for two associates. When the method was new, these nurses were sent to Baltimore, Philadelphia, or New York for several weeks' training by Dr. Hingson or Dr. Edwards. These courses are no longer available, but these pioneer labor nurses, with the aid of local obstetricians, have trained their successors down through the years. A new nurse will understudy a practicing labor nurse for approximately six weeks before she will be allowed to administer continuous caudal analgesia by herself. The caudal technique is easily learned; indeed, it is usually mastered much more quickly than are rectal examinations.

The doctor inserts the caudal catheter and ruptures the membranes. He may then go to the office or to bed. The nurse administers the Metycaine, checks the level of anesthesia, the blood pressure, the fetal heart sounds, and the progress of labor. She notifies the doctor when the patient is ready for delivery. He naturally gives orders for any medication. When stimulation with oxytocin is necessary, she is instructed to give fractional doses of Pitocin in a dilution of 1:10. She never gives more than the equivalent of 1 minim of undiluted Pitocin. By rule of the Department of Obstetrics, Pitocin infusion is given only when the doctor is in attendance. Oxygen by inhalation is given freely during labor and routinely for 5 to 10 minutes prior to delivery.

The patient pays the labor nurse a standard fee for services regardless of the length of her attendance during labor. The obstetrician may guarantee his nurse a minimum salary per month, but her income is in proportion to the number of labor cases she attends. The work is strenuous and tiresome, but the financial reward is relatively good as compared with other nursing salaries.

Under this system, continuous caudal analgesia has proved to be a practical, convenient method of pain control, even in a private obstetric practice.

Summary and Conclusions

One year's experience with continuous caudal analgesia as a routine technique for labor and delivery (371 cases) has been reviewed.

1. The duration of labor is usually shortened under caudal analgesia as used here, but was slowed in some cases (13 per cent).

2. There were slightly more transverse arrests and occiput posterior presentations, but owing to the soft tissue relaxation, correction was relatively easy. The incidence of mid-forceps deliveries was also increased (15.4 per cent) but were also easily managed.

3. Caudal analgesia offered excellent analgesia and relaxation in 97 per cent of the patients.

4. The technique is safe for both mother and fetus. There were no maternal deaths or injuries, and no post-anesthetic headaches. Some 95 per cent of the infants cried spontaneously within the first minute of life.

5. Hypotension is the greatest single hazard encountered. This complication can easily be controlled by skilled management of the patient.

6. Patients' acceptance of caudal analgesia was high. Ninety-six per cent would request it again; 95 per cent preferred it to other types of anesthesia they had had previously.

7. The use of the labor nurse as a member of the obstetric team makes the routine use of continuous caudal analgesia quite applicable in private practice.

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Discussion

Dr. Sam L. Parker, Jr. (Kinston):

Pain is no longer a necessary component of normal delivery. In our modern age some form

of anesthetic is available in standard hospitals for every American mother requiring or desiring it.

One-half of American babies today are being born with some form of conduction block anesthesia—that is, two million out of four million babies being born each year are delivered with regional anesthesia.

Hingson stated in 1945 that continuous caudal anesthesia, when properly administered, will completely relieve the pain of labor and delivery. Nevertheless, the limitations of the technique should be evaluated. It is not a procedure to use in the home and in the poorly staffed hospital. This eliminates more than 70 per cent of American births from consideration. In addition, 40 per cent of mothers delivered in well staffed maternity units present contraindications prohibiting its successful use. Thus, if every hospital in the United States utilized this form of obstetric management in every suitable case, only 12 per cent of women would benefit from this form of pain relief. The truth remains that not more than one hospital in ten is utilizing this technique at all. Less than 1 per cent of American mothers will accept this method.

The following conditions are contraindications to the method:

1. An easy, almost precipitate labor, or delivery in less than 40 minutes after the patient's arrival at the hospital. (These patients need only whiffs of gas.)
2. Apprehensiveness, nervousness, and the desire to be asleep during delivery.
3. Gross deformities or disease of the central nervous system, or emotionally unstable personalities.
4. Extreme obesity—because of the technical difficulties involved.
5. Local infection or the presence or history of piloidal cysts.
6. Profound anemia and dehydration, unless supplementary oxygen inhalation or intravenous fluids are given.
7. Obstetric complications — placenta previa, abruptio placenta, monstrosities, predetermined stillbirths, and others.
8. A history of sensitivity to the analgesic agent.

The successful use of caudal analgesia will depend upon organization and teamwork between the obstetric and anesthetic staff, with an adequately trained nursing supplement. Procedures that should be adopted are:

1. The physician using the technique should have a period of special training.
2. The patient should be surrounded with such safeguards as readily available oxygen, vasopressors, and sterile lumbar puncture needles for withdrawing the occasional inadvertent massive spinal injection.

3. Use of the Bishop X-ray for study of the sacrum to rule out anomalies.

Continuous caudal anesthesia should not be continued indiscriminately. It was designed to relieve the pain, not the early discomfort, of labor.

In 1958 the Lenoir Memorial Hospital at Kingston had a total of 1,020 deliveries. Anesthetic methods used during this period were as follows:

	No.	Per Cent
Trilene (trichloroethylene)	594	58.2
Pudendal block and Trilene	150	
Local infiltration and Trilene	63	
Gas-oxygen-ether	8	
Saddle block	48	
Spinal anesthesia for cesarean and terminal	17	
Caudal analgesia	9	
Hypnosis and pudendal block	2	
None	18	

The types of delivery performed in the same period were:

	No.	Per Cent
Spontaneous	790	77.4
Low forceps	147	14.4
Mid-forceps extraction	4	
Mid-forceps rotation and extraction	8	
	12	1.1
Breech presentation	53	5.2
Spontaneous	7	
Assisted	19	
Extraction	23	
Decomposition and extraction	3	
Version and extraction	1	
Compound pres.	1	0.1

It can be seen that the incidence of spontaneous deliveries in our hospital was 77.4 per cent, and the incidence of total operative procedures, including cesarean sections, was 21 per cent. The percentage of low-forceps deliveries was only 14.4, and of mid-forceps rotations and extractions 1.1. There were 11 cesarean sections, for a rate of 1.1 per cent.

The author's percentage of mid-forceps deliveries is high (15.4), and I wonder if it could not have been decreased with the use of Pitocin stimulation by the infusion method. Mid-forceps deliveries usually result in other complications, which were not mentioned. The length of labor was prolonged with the use of caudal analgesia. Thirty per cent of the primigravidas were in labor 16 hours or longer, and 11 per cent of the multiparas were in labor longer than 16 hours. The use of caudal analgesia from the outset for decomposition and extraction is questionable. A general anesthetic is indicated for this operative delivery.

In our small community hospital we do not

have the trained personnel nor the time to sit with the patient, as required by the continuous caudal method; neither do we have round-the-clock coverage by the anesthesia department for general anesthesia. Therefore we are forced to use other methods. When patients request it and when it is feasible, we may employ the terminal, simplified technique of caudal anesthesia. With this method the only equipment needed is a prep forceps and agent, a 30 cc. syringe and a 1½ inch 22 gauge needle and 30 cc. of a 1.5 per cent solution of xylocaine. The needle is introduced beneath the sacrococcygeal ligament in proximity to the caudal canal. The injection is made, and if the needle is properly placed, the agent will flow superiorly into the sacral canal. If improperly placed, a subcutaneous swelling is noted. The only disadvantage is that the analgesic effect lasts less than two hours; however, this is all the time needed for many multiparas.

The advantages of the method are:

1. It is a simple manipulation, requiring no special needles or equipment.

2. There is little trauma or pain.
3. Subarachnoid injection is impossible.
4. Most sacral abnormalities do not prevent block.
5. The patient's position is not important.
6. Bleeding is rare.
7. There are no broken needles.

The conduction block technique that we use most often in our hospital is the regional pudendal nerve block, which in our practice is far more practical, much easier to administer, and without doubt the safest of all obstetric anesthetics. Uterine contractions are not affected in any way. Good anesthesia of the pelvic floor results, but since the bearing-down reflex is abolished, the patient must be encouraged to bear down. This method is satisfactory for spontaneous deliveries, low forceps deliveries, spontaneous breech deliveries, for low forceps to the after-coming head, and for episiotomy and perineorrhaphy.

Vitamin Supplements and the Incidence of Colds in High School Basketball Players

A Preliminary Report

FRANK E. BARNES, JR., M. D.

SMITHFIELD

The incidence of colds among players on high school basketball teams can be a very real problem from the point of view of winning games and league championships. This is important to the teen-ager and to the school, and is part of the larger problem of keeping this age group in good health and able to do its best both in athletic and academic activities.

It has been recognized for some time that during periods of rapid growth nutritional requirements are greatly increased. The nutritional needs of infants and young children during their development have received much attention, but the adolescent does not always get his share of attention. Many adolescents eat too little, and many more eat poor combinations of food¹. A number of surveys of the diets of teen-agers indicate that they do not receive enough vitamins. One survey² indicated that supplemental vi-

amins and minerals given to school children resulted in significant gains in both academic attainment and growth. The ratio of growth increased from the tenth year to the degree that "in the girl's thirteenth year, and the boy's sixteenth year, the ratio of gain is double that seen in the early years of school life."³ In discussing adolescents, Fischer⁴ states that "subclinical vitamin deficiency is quite common in this age group and in some instances there may even be typical avitaminoses."

A recent report⁵ on the basis for concern about the diet of teen-agers states that "there is little question that this age group as a whole practices limited judgement in the choice of total food eaten." Two of the shortcomings cited are suboptimal supplies of vitamin A and insufficient ascorbic acid. The stresses which occur during adolescence are also discussed—accelerated growth and

Table 1
Composition of Theragra-M Tablets

	<i>Contents of One Tablet</i>
Vitamin A	25,000 U.S.P. units
Vitamin D	1,000 U.S.P. units
Vitamin K	2 mg.
Thiamine mononitrate	10 mg.
Riboflavin	10 mg.
Pyridoxine hydrochloride	5.0 mg.
Vitamin B12 activity concentrate	5 mcg.
Folic acid	0.1 mg.
Niacinamide	100 mg.
d-Calcium pantothenate	20 mg.
Ascorbic acid	200 mg.
<u>Vitamin E</u>	<u>5 International units</u>
Calcium	105 mg.
Iodine	0.15 mg.
Iron	15 mg.
Potassium	5 mg.
Copper	1 mg.
Manganese	1 mg.
Magnesium	6 mg.
Zinc	1.5 mg.

inefficient use of certain important substances as a result of frequent, important emotional problems.

Although boys and girls playing basketball are usually in good physical condition as compared with the majority of high school students, they have the added stress of greater and more frequent exposure to changes in temperature, since they play in hot gymnasiums, take showers, and go out into cold air on repeated occasions.

Materials and Methods

In North Carolina it is well known that high school students eat a poorly balanced diet. Recent studies made by student nurses from the University of North Carolina Nursing School revealed that the majority of the students have an inadequate diet. A very small percentage drink a glass of milk a day, but many seem to survive on hot dogs and cola drinks. As a means of supplementing these diets and of observing the effects of multivitamins in fortifying the students against winter ills, a program was worked out with the staff and students of the Smithfield, North Carolina, High School. The school officials were enthusiastic, and cooperated in keeping daily charts on the progress of the study.

High levels of ascorbic acid were considered to be necessary to ward off the usual

run of colds, a fact that was taken into consideration in the choice of a supplemental vitamin preparation. Theragra-M* was chosen after the many vitamin preparations available were evaluated for the present purpose. The composition of this preparation is given in table 1.

The boys' and girls' basketball teams, 26 players in all, were examined for upper respiratory infections, and histories of recent colds or sore throats were taken before the study was begun. When first seen, 7 boys and 4 girls had colds or evidence of recent upper respiratory infection. None was severely ill.

The coaches of the teams were put in charge of dispensing the vitamin tablets, one of which was given to each player every day for approximately seven weeks. If a cold or sore throat was reported either at practice or before a game, this was recorded. Each player was given a supply of tablets to take over the week-end while he was at home. An attempt was made to keep the players on the vitamin preparation for the full seven days of every week. Sixteen other boys and girls of the same age and background as the players served as a control group and reported daily to the coaches.

*Supplied by The Squibb Institute for Medical Research, New Brunswick, New Jersey.

Table 2
The Effect of Vitamin Supplements on the Incidence of Colds
in High School Students

(Total Study Period, 848 Days)

Control Group (8 boys, 8 girls)				Group Receiving Vitamins					
January 13 to March 6				Boys (10)		Girls (13)			
Sex	No. Days with Colds	No. Days Absent	Boys	January 13 to March 6 Days of Medication	Days with Colds	Girls	January 13 to February 26 Days of Medication	Days with Colds	
JB*	F	10	..	EB	38		PA	43	9**
SC	F	7	2	RB	47	2	AB	43	1**
BC	F	4	..	CW	47	1	MAB	43	5**
BCr	F	9	3	PE	47	2***	LB	43	0
MD	F	4	..	MG	47	3***	BLC	43	0
SNH	F	..	..	SBMc	46	1	PE	43	0
KJ*	F	19	..	JO	42	2	PH	41	0
JO	F	7	..				NL	43	3
				TH	47	1			
TE	M	6	..	DL	46	3	MC	43	0
BG	M	11	..	SS	46	1	AC	43	0
JOg	M	8	1				LH	43	1
TO	M	9	2				SH	42	0
CO*	M	7	..				BB†	22	0†
JS	M	..	..						
BW	M	..	..						
CY*	M	9	..						
16		110	8	10	454	16	13	535	18

* At least two colds

** Very light colds

*** One day each, mild colds

† Added to group during third week of study
 "Flu" for five days

Records of absences from classes for all students in both groups were also kept. The parents and, if necessary, the family physician were consulted before the medication was initiated. Only two parents asked that their children not be given the vitamins, since these children were on special diets and were receiving other vitamin preparations at that time.

Results

Experimental groups

The results are summarized in table 2. Almost from the start of the experiment there were complaints among the boys who had been receiving their tablets just before practice, of abdominal cramps and some diarrhea (6 boys complained of this condition during the first week). None of the girls who received the tablets just after practice had these symptoms. When the

coaches changed the procedure and gave both groups their vitamin preparation after the practice sessions or games, the symptoms subsided. One boy, however, stopped taking the preparation during the third week of the study at the request of his parents, who felt that it might be causing his vague abdominal complaints. Another boy stopped taking the vitamins during the fourth week of the study because he thought the tablets were causing indigestion. The rest of the players experienced no other symptoms during the remainder of the study.

The girls' basketball team was made up of 13 players, one of whom refused to take the preparation being tested since she was on a diet. The group as a whole, consisting of 12 players, had 19 days of colds and five days of "flu." One girl reported a cold for nine days, another a cold for five days. Two girls,



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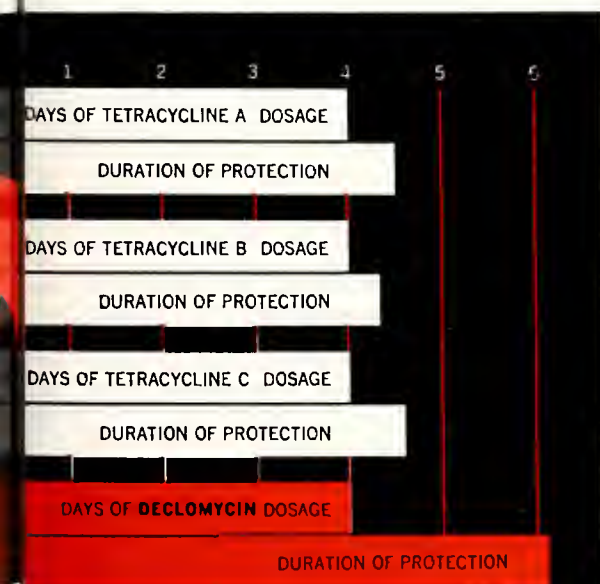
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5,000	5,000 to 10,000	50.00 Weekly	\$ 78.00	\$ 39.50	\$104.00	\$ 52.00
5,000	7,500 to 15,000	75.00 Weekly	114.00	57.50	152.00	76.00
5,000	10,000 to 20,000	100.00 Weekly	150.00	75.50	200.00	100.00
5,000	12,500 to 25,000	125.00 Weekly	186.00	93.50	248.00	124.00
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therefore, were responsible for 14 of the total of 19 days when colds were reported. One of these two girls on four days, had only suggestive symptoms of a cold. It is noteworthy that only two days were missed by the entire group of 12 girls during their seven weeks of school. A new girl joined the team in the third week of practice and promptly had a case of influenza lasting five days. During the time of the study, 535 tablets were dispensed to the girls, and no ill effects were observed in this group.

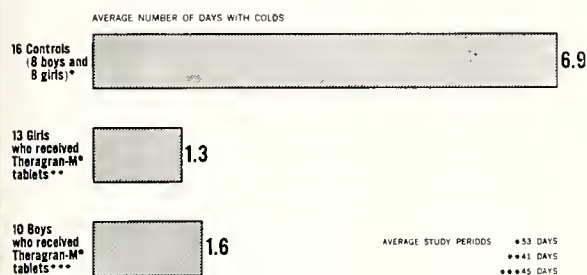


Fig. 1

The boys' basketball team was also made up of 13 players at the beginning of the study, but 3 boys stopped taking the vitamins before it was completed. A total of 454 tablets were dispensed. The majority of colds in the boys' basketball team were noted during the first week of practice—four days of colds involving 3 boys—and only two days of school were missed out of the entire eight weeks.

An unusual circumstance was that 7 boys reported with colds on the same day in the fourth week, but none was noted to have any cold the rest of the week. They had played a hard, rough game the night before, a circumstance that was repeated during the sixth week, when 6 players reported for practice with colds on a Monday, but no colds appeared during the rest of the week. It was questioned whether this was just the effect of strenuous exercise or undue activity over the week-end, since the colds completely disappeared in a 24-hour period. A total of 13 days with colds were reported by this group in two days, and none thereafter. An aggregate of 16 days with colds was reported by members of the boys' basketball team.

Control Group

The control group, made up of 8 boys and 8 girls, differed markedly from the two groups receiving vitamins as to the total number of days on which colds were reported, and the days missed from school. This control group reported 110 days with colds out of a total number of 848 days. Five of the group had colds twice during the period of the study, and only 3 out of the entire group had no colds or other sickness at any time during the study. Eleven had at least one week of colds. Three had 10 or more days of colds or evidence of influenza. The group as a whole missed eight days of school.

Comment

The coaches and the school officials noted a definite improvement in the students given the vitamin supplementation, both in their attitudes and playing ability, from that observed in previous years when no supplements had been given. The coaches were enthusiastic about the greatly reduced number of absences from practice and games. They are interested in continuing the vitamin supplements in future years, not only with the basketball teams but also with the football teams, since the bitter, cold weather of October and November is usually productive of colds and disrupts the athletic program.

Summary and Conclusions

1. Records were kept of the incidence of colds for approximately eight weeks in a total of 39 high school students. Of this group, 13 girls and 10 boys received Thera-gran-M (a multivitamin supplement), and regularly 16 boys and girls of comparable age and background served as controls. The two groups who received the vitamins were members of the basketball teams.

2. The control group reported with colds on an aggregate of 110 days during the study period. The 10 boys who received 454 Thera-gran-M tablets reported colds on 16 days, and the 13 girls who received 535 tablets reported colds on 18 days. This was an average incidence of 6.9 days of colds for the controls, but for those who received vi-

amins it was 1.6 days for the boys and 1.3 days for the girls.

3. Although the number of students in the two groups was small, it is believed that the vitamins definitely improved the health of the students. It is suggested that all high school students need multivitamin supplements, particularly during strenuous athletics in the fall and winter months.

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Report from The Duke University Poison Control Center

J. M. ARENA, M.D., *Director*

LEAD POISONING

While lead poisoning ordinarily suggests a slowly developing occupational disease of adults, in children there can be acute manifestations characterized by stupor, convulsions, and coma—the features of an encephalopathy—and progression to sudden death.

Lead poisoning in children is still too frequent. The reforms that were adopted with awareness of the toxicity of lead—such as avoiding its use for interior paints—did not, unfortunately, remove older buildings from the scene. Furthermore, outdoor house paints may still contain lead. The policy of not using lead paint on toys, or lead in "lead" soldiers, does not protect children from imported playthings or older paraphernalia that may be as hazardous as ever. Besides the normal curiosity typical of small children, there is often a craving for unusual things to eat (pica), including flakes of old paint.

Lead poisoning is most frequent in children 1 to 5 years of age, and occurs especially

during the summer months, possibly because vitamin D may enhance the absorption of lead in the same way as that of calcium. Lead is thus absorbed chiefly from the digestive tract and is distributed throughout the viscera, especially in the liver and kidneys, until it is taken up and stored in the skeleton as an insoluble, biologically inert, tertiary lead phosphate. Like calcium it can be mobilized from the skeleton in metabolic states such as acidosis, or conversely, can be deposited from the circulation during alkalosis. In addition, poisoning can be caused by absorption of lead through the skin and by inhalation. Since the use of lead-containing ointments and wet dressings has been discarded by dermatologists, intoxication by absorption is rarely encountered. However, when lead enters the body through the respiratory tract, signs of intoxication develop more quickly than when tenfold the amount is ingested. Epidemics of severe poisoning with tragic involvement of the central nervous system resulting from the inhalation of lead fumes from the burning storage battery boxes for fuel have been reported in Baltimore, Philadelphia, Detroit, and other cities.

Diagnostic Criteria

1. Clinical and Laboratory Criteria
 - A. Gastrointestinal Manifestations
One or more of the following:
 - (1) Anorexia
 - (2) Intermittent vomiting
 - (3) Abdominal pain
 - (4) Constipation
 - B. Manifestations of the Central Nervous System
One or more of the following:
 - (1) Irritability
 - (2) Drowsiness
 - (3) Persistent vomiting
 - (4) Incoordination
 - (5) Convulsions
 - (6) Coma
 - (7) Weakness or paralysis
 - (8) Hypertension
 - (9) Papilledema and/or optic atrophy
 - (10) Paralysis of one or more cranial nerves
 - (11) Elevated protein content of the cerebrospinal fluid
 - (12) Cerebrospinal fluid pleocytosis
 - (13) Elevated cerebrospinal fluid pressure
 - C. Hematologic Manifestations
One or both of the following:
 - (1) Hypochromic microcytic anemia

- (2) A significant degree of basophilic stippling of the red blood cells
- (3) 75-100 per cent red fluorescence in erythrocytes examined under ultraviolet light

D. Excessive Coproporphyrinuria

E. Urinary findings

One or both of the following:

- (1) Glycosuria
- (2) Amino-aciduria

F. The demonstration of increased radiologic density at the metaphyses of long bones

2. Criteria for Lead Absorption

The following findings present evidence of absorption of lead in quantities that are known to be capable of inducing intoxication.

A. A concentration of lead in the blood, as determined by a method of known high sensitivity and precision, of 0.08 mg. per 100 Gm. of whole blood or greater. Values of 0.06-0.08 mg. per 100 Gm. of whole blood are indicative of abnormal absorption of lead, but often not a degree of absorption which is capable of inducing symptoms of intoxication. Repeat determinations are preferred.

B. Urinary excretion of lead, as determined by methods of analysis of known high sensitivity and precision, in amounts of 0.08 mg. or more per 24 hours in patients not receiving treatment to increase lead excretion. Repeat determinations are preferred.

3. Exposure to a Lead Source

A confirmed history, by chemical identification of the source, of exposure to lead of such a severity and of such duration as to be indicative of a dangerous degree of absorption.

Clinical and Laboratory Criteria

The child who is poisoned by lead will have taken in and absorbed dangerous amounts of the material. The presence of clinical and laboratory manifestations in such a child enables a diagnosis of lead poisoning to be made.

Manifestations included under clinical and laboratory criteria are nonspecific, since any of them can be found in other illnesses. Even the increased radio-opaque areas or lines at the metaphyses of the long bones are not specific indications of lead absorption, for these are seen with other diseases—for example abnormal absorption and storage of other heavy metals and healing rickets. Such lines are not indicative of intoxication, but occur so frequently in small children who are absorbing abnormal amounts of lead as

to serve as a warning. A child exhibiting this manifestation should be investigated carefully with respect to the amount of lead absorbed.

When any two of the criteria listed under clinical and laboratory criteria for lead occur together with one of the criteria for lead absorption, a diagnosis of lead poisoning may be made.

Two or more of the clinical and laboratory criteria listed may be used to make a presumptive diagnosis of plumbism in children with early manifestations of increased intracranial pressure; such children require removal from the source of lead and emergency treatment. A delay in treatment while a blood or urine analysis for lead is being performed may be hazardous. Edathamil calcium disodium (calcium EDTA or edathamil) therapy can be instituted while blood or urine determinations are being performed. Treatment can be stopped if repeated lead analyses show the provisional diagnosis to be in error.

The central nervous system is frequently involved in children with lead poisoning. When involvement is such that abnormal cerebrospinal fluid findings such as increased pressure, elevated protein and variable cell count up to 100, almost all lymphocytes, become manifest, the diagnosis of lead poisoning with encephalopathy may be made.

Excessive coproporphyrinuria is a constant finding in acute episodes, and the urinary porphyrin test is a simple and quick screen test for lead intoxication. It is based on the fact that a normal constituent of urine, porphyrin (principally coproporphyrin type III) is increased in lead poisoning. Theories differ as to its origin, some investigators believing that it is the product of faulty synthesis of hemoglobin, others that it represents the result of a break-down of hemoglobin.

Urinary porphyrin test

Method

1. Pipette 10 cc. of a "random" sample of urine into a screw top tube.
2. Add 2 drops of glacial acetic acid.
Add 2 drops of hydrogen peroxide.
Add 2 cc. of ether.

3. Mix gently in screw top tube.
4. Let stand 30 minutes.
5. View in dark room using an ultra-violet lamp.
6. Record any pink fluorescence of the surface ring as *positive*.

There is no correlation between the quantitative amount of lead in the urine and the presence of a positive porphyrin reaction. The test may vary from positive to negative in the course of a few months' time, or it may stay positive long after cessation of exposure to lead when damage supposedly exists.

Criteria for lead absorption

Once the suspicion of lead poisoning is aroused, the most important single consideration in the differential diagnosis is whether or not lead has been absorbed in quantities sufficient to induce illness. This can best be demonstrated by determining the lead content of the blood. The threshold value cited above, 0.08 mg. of lead per 100 Gm. of whole blood, is a critical one. Lead concentrations between 0.06 and 0.08 mg. per 100 Gm. of whole blood are indicative of abnormal absorption of lead, but often not of a degree which is capable of inducing symptoms of intoxication.

Extensive studies have been made on the variability of the concentration of lead in the blood and urine of adults and children, both under ordinary circumstances and under conditions of abnormal exposure to lead. In a group of children between the ages of six months and four years, in whom there was no evidence of abnormal intake and absorption of lead, the average blood lead concentration was 0.027 mg. per 100 Gm. of blood. In a recent report the upper normal limit of blood lead concentration in young children is stated to be 0.05 mg. per 100 Gm. of blood.

(To Be Continued)

18TH ANNUAL
WATTS HOSPITAL
MEDICAL AND SURGICAL SYMPOSIUM
FEBRUARY 3-4, 1961
AT
JACK TAR DURHAM HOTEL
AND WATTS HOSPITAL

SPECIAL REPORT

REPORT ON ACTIONS OF THE HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION FOURTEENTH CLINICAL MEETING*

November 28 - December 1
Washington, D. C.

A scholarship and loan program for medical students, the status of foreign medical graduates, an A.M.A. membership dues increase, the expansion of voluntary health insurance, health care for the aged, and new developments in polio vaccine were among the major subjects acted upon at the American Medical Association's Fourteenth Clinical Meeting held in Washington, D. C., November 28 - December 1.

Named as 1960 General Practitioner of the Year was 44 year old Dr. James T. Cook of Marianna, Florida, who was selected for his dedication to both medical practice and service to the community. Dr. Cook is the fourteenth recipient of the award.

Speaking at the Monday opening session, Dr. E. Vincent Askey of Los Angeles, A.M.A. President, called upon the delegates to support not only existing A.M.A. programs but also expansion of new programs necessary to meet the challenges of society. Dr. Askey assured the new administration in Washington of cooperation whenever and wherever possible, but emphasized that the A.M.A. will not change its policies merely for the sake of conformity.

Total registration reached 8,170, made up of 3,940 physicians and 4,239 guests.

SCHOLARSHIP AND LOAN PROGRAM

The House of Delegates approved a scholarship and loan program proposed by the Special Study Committee of the Council on Medical Education and Hospitals, and also urged that there shall be local participation in the program at the state and county level. In commenting on the two-part program, the House approved the following statement by the reference committee:

This proposed program will provide concrete

* This report was submitted for publication by Dr. Ellas S. Faison, Secretary of the North Carolina delegation to the House of Delegates, American Medical Association.

evidence of the American Medical Association's sincere desire to attract increasing numbers of well qualified young people to enlarge the ranks of our profession. Your reference committee recognizes that the program is wisely designed to allow for its enlargement through the support of individual physicians and other groups. Your reference committee was impressed with the enthusiastic support of this proposal indicated during the course of the discussion. There was indicated a desire that in the final formulation of the administrative details of this program, provision be made for widespread participation by individual physicians as well as county and state medical societies. The program will clearly assist in securing highly talented individuals whose ability and leadership in all areas of medicine will be fostered and at the same time will bring needed financial assistance on a broad basis to medical students under a system in keeping with this Association's belief in individual responsibility.

FOREIGN MEDICAL SCHOOL GRADUATES

Meeting the problem of foreign medical graduates, the House of Delegates adopted a report which included the following statements:

In order that those foreign physicians who have not yet been certified by the Educational Council for Foreign Medical Graduates might be given further opportunity to enhance their medical education, hospitals would be encouraged to develop special educational programs. Such programs must be of educational worth to the foreign graduate and must divorce him from any responsibility for patient care. Foreign physicians may participate in these programs until June 30, 1961, with approval of the Department of State so that their exchange visa will not be withdrawn before that time. This will also allow the non-certified foreign physician the opportunity to take the April, 1961, Educational Council for Foreign Medical Graduates examination.

A.M.A. DUES INCREASE

The House approved a Board of Trustee report which announced that a dues increase would be recommended at the annual meeting in June, 1961. The report indicated that the amount would be not less than \$10 and not more than \$25, to be effective January 1, 1962. The Reference Committee asked the Board to consider an increase in the annual dues of \$20.00, to be implemented over a period of two years: \$10.00 on January 1, 1962, and \$10.00 additional on January 1, 1963.

The House suggested that these funds be used to inaugurate or expand a number of programs including:

1. Financial assistance to medical students.
2. Continuing education for practicing physicians.
3. Health advice to the lay public.
4. Medical research.
5. The expansion by the Communications Division of its program of faithfully portraying the image of the American Medical Association.

It is important, the House emphasized, that the Board of Trustees report recommending a dues increase be transmitted in essence to the grass roots level.

VOLUNTARY HEALTH INSURANCE

In place of a Board of Trustees report and three resolutions, the House adopted the following substitute resolutions:

Whereas, It has been widely recognized that voluntary health insurance is the primary alternative to a compulsory governmental program; and

Whereas, The public has shown its confidence in this voluntary system; and

Whereas, Current social, political and economic developments compel a new and revitalized effort to make voluntary health insurance successful; and

Whereas, The American Medical Association has consistently pledged itself to make available the highest type of medical care; therefore be it

Resolved, That the House of Delegates direct the Board of Trustees and the Council on Medical Service to assume immediately the leadership in consolidating the efforts of the American Medical Association with those of the National Association of Blue Shield Plans, the American Hospital Association and the Blue Cross Association into maximum development of the voluntary, non-profit prepayment concept to provide health care for the American people; and be it further

Resolved, That similar leadership be undertaken to coordinate the efforts of private insurance carriers through conferences with their national organizations; and be it further

Resolved, That, where feasible, efforts be made to cooperate with representatives of other types of medical care plans, other professional groups, and representatives of industry, labor and the public at large.

HEALTH CARE FOR THE AGED

The House reaffirmed the Association's

support of the Kerr-Mills Bill, which was passed last summer, and its opposition to any legislation involving the use of the OASDI mechanism for medical aid to the aged. The delegates also urged all state and local medical societies to cooperate with the appropriate state officials and provide leadership in implementing the provisions of the Kerr-Mills Bill.

In connection with health care for the aged, the House suggested further experimentation in home care programs, home-maker services, and visiting nurse services. The delegates also recommended an increased emphasis at all levels of medical education on the new challenges being presented to physicians in the health care of older persons.

POLIO VACCINE

The House agreed with a Board of Trustees report which said:

In view of the fact that oral polio vaccine will not be generally available in sufficient quantity in 1961 for any large scale immunizing effort, the Board of Trustees of the A.M.A. strongly recommends that the medical profession encourage the widest possible use of the Salk vaccine for the prevention of poliomyelitis. The Salk vaccine has been proved to be effective and since there are still many segments of the population not immunized against poliomyelitis every effort should be made to encourage the general public to take advantage of the Salk vaccine without delay.

The Board report was amended to suggest that a proper committee be established by the A.M.A. to study the problems involved in administration of the new oral polio vaccine and to establish guides for physicians to follow when they are ap-

proached by various groups and asked for their support in administering oral polio vaccine.

MISCELLANEOUS ACTION

In considering a wide variety of resolutions and annual and supplementary reports, the House also:

Approved continuing study and periodic re-evaluation of the trend toward locating *physician's offices* in or adjacent to hospitals;

Directed the Committee on Medical Care for Industrial Workers to carry out its duties as previously instructed and to prepare guides for physician relationships with *medical care plans* in conformity with the clear policies already laid down by the House of Delegates;

Approved a set of guides relating to drug expenditures for *welfare recipients*;

Asked the Board of Trustees to study the question of blood replacement responsibility and also the matter of establishing health insurance fee schedules for *surgical assistants*;

Urged the Board to make every effort to reduce the number of physicians who are non-dues-paying members and approved a three-year study report on the relationships of *physicians not in private practice* to organized medicine;

Requested the Board to present a completed *retirement* and *disability* insurance program for A.M.A. members at the June, 1961, meeting, and

Agreed that the General Practitioner of the Year Award should be continued as at present.

F. J. L. BLASINGAME, M.D.

Amongst the essential tools in a doctor's kit is a nature with a southern exposure that brings optimism and hope to his patient. But an even more effective tool is the habit of worrying about those who entrust their health to him.—Levine, S. A.: Worry—Where Will It Get You? The Pharos 23: 213 (Oct.) 1960.

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JANUARY, 1961

THE A.M.A. CLINICAL SESSION

Elsewhere in this issue will be found a summary of the actions of the House of Delegates as prepared by the efficient Executive Vice President of the A.M.A., Dr. F. J. L. Blasingame. This summary relieves the secretary of the North Carolina delegation from the task of preparing a report. A few items of interest to North Carolina doctors, however, should be added.

Dr. Charles F. Strosnider, chairman of the North Carolina delegation, had to miss his first meeting in many years because of illness. It is good to know that he is now much improved. His place was taken by his alternate, Dr. Edward W. Schoenheit, who attended every meeting faithfully. Other delegates from North Carolina were Drs. Millard D. Hill of Raleigh and Elias S. Faison of

Charlotte. Dr. Wingate Johnson was ex-officio member as a former trustee.

The North Carolina Delegation introduced a resolution asking that the A.M.A. oppose the ambulatory clinic plan of treating narcotic addictions and support measures to require civil commitment of drug addicts for treatment in a medically managed institution; encourage measures to rehabilitate the addict; and establish methods for disseminating factual information on narcotic addiction to members of the medical profession.

This resolution was referred to the Council on Drugs, and will probably meet with favorable action.

The interim meeting was well attended. The number of exhibits was small as compared with the annual session in June, but they were very good.

An objectionable feature of the Miami Beach Meeting applied to this one also: the meeting places were too far apart. Many miles separated the headquarters Sheraton Park Hotel from the National Guard Armory, where the exhibits and scientific sessions were held. The Statler-Hilton, chosen for the Delegates' Dinner, was also some distance away. Many wondered why the dinner was not held in the Sheraton Park Hotel or why the Statler-Hilton was not made headquarters.

Honor guest at the Delegates' Dinner was Dr. Howard Snyder, President Eisenhower's physician. Quite a few eyebrows were raised by those paying \$12.50 for admission to the dinner. It was well worth the price, however, to hear the music rendered by the Army Choir, and to note the response of the audience to the tribute paid by President Vincent Askey to Dr. Howard Snyder.

The question of health care for the aged was, of course, the principal topic of conversation. It is well covered in Dr. Blasingame's report.

A real highlight of the meeting was President Vincent Askey's address at the opening session of the House of Delegates. He has proved himself a worthy successor of a long line of able men.

THE PHYSICIAN AND THE VA PROGRAM

In the *Texas State Journal of Medicine* for August, Dr. M. V. Davis, chairman of the Texas Medical Association's Committee on Military and Veterans Affairs, criticizes physicians in private practice for abetting the VA program, which he says is really socialized medicine. Dr. Davis charges that physicians encourage the program by referring patients to VA hospitals — most of them for non-service-connected disabilities.

Another charge is that medical schools approve the VA program by approving residences in VA hospitals and by participating in the VA teaching program. He says that VA officials justify admitting patients with non-service-connected disabilities on the grounds that they are essential for maintaining their residency program. Since the VA hospitals pay higher salaries than most non-governmental ones, they can more easily fill their house staff positions.

Dr. Davis concludes his statement with this paragraph:

"The Association's Committee on Military and Veterans Affairs has looked hard for a solution. There seems to be only one ultimate answer. The only way that operations of the VA Hospital system will be curtailed is to decrease Congressional appropriations. The only way that Congressional appropriations will be decreased is by a marked and sustained decrease in the in-patient census of VA hospitals, and the only way that physicians can decrease the in-patient census is to stop sending patients to VA hospitals. This means physicians in their private offices, in private hospitals and clinics, in city-county and other public hospitals, in clinics and emergency rooms, and everywhere. There really is no other solution."

The remedy proposed by Dr. Davis is a drastic one. So many veterans demand that they be referred to a VA hospital for non-service-connected disability and are offended if their request is refused that the situation is analogous to the use of Blue Cross Insurance for purely diagnostic surveys. An argument that may discourage a veteran from seeking referral to a VA hospital in-

stead of a non-governmental one is that much time is wasted in order to pad the bed-occupancy list. Most doctors can recall patients having been kept for weeks in a VA hospital for tests that would have taken only a day or two in a non-governmental one. If a veteran's time is worth anything, he will often save money by going to a non-governmental hospital.

* * *

AS OTHERS SEE US

At the St. Louis meeting of the Southern Medical Association the William S. Merrell Company presented a panel on medical economics. One of the speakers, Mr. Woodrow Wirsig, editor of *Printer's Ink*, discussed three surveys he had made within the past two years. A summary of his remarks is given so that our readers may see ourselves as others see us.

Mr. Wirsig finds that the public is developing a strong resentment toward doctors. It seems to make little difference to them that United States medical services are the best anywhere in the world.

A poor image of the American physician is shared by too many of our patients. An "image" in modern communication terms is a deep-rooted attitude, something people think or believe, whether really true or not.

What has caused this unfavorable and hostile attitude of the very people whom the doctor dedicates his life to serving? One reason, Mr. Wirsig finds, is that though we have become more skilled and learned, doctors as a group appear to be unaware of social, economic, and political demands moving like a whirlwind toward them.

Doctors know better than anyone that change is constantly reshaping our lives. Everything changes. Education gets better or worse; communications improve or fail; people learn more or less. Mr. Wirsig warns that the public is today aware that social patterns lag behind the developments of science — and they are now no longer willing to accept this lag. So, Mr. Wirsig tells us, the physician's tarnished image in the minds of the public presents a threat and a challenge. Unless doctors themselves find a way to meet the challenge, someone else

will do it for them. Editor Wirsig, troubled over the consequences, cautions that we must realize that the nation's health has ceased to be the concern only of individual citizens. Now it is a matter of universal concern. Like it or not, health has become a national asset to be regarded by many as the government's responsibility.

Here is Mr. Wirsig's prescription: Medicine, while it may have difficulty keeping up with the economic-social changes, nevertheless must keep up, change, and lead the way if it is to survive in any recognizable form as we know it today. Doctors must take the initiative in health care programs and come forward with whatever plan is necessary. Doctors have the knowledge with which to work their own salvation at a time of crisis. They can do it brilliantly — and, if they don't, someone else will.

* * *

PARAPLEGICS SAY THANK YOU

It will be generally agreed that gratitude is far less common than it should be. Therefore, though the traditional season for giving thanks is past, the following editorial from the Bulletin of the North Carolina Paraplegia Association bears repeating here, particularly in view of the growing interest in rehabilitation.

NOW THANK WE ALL

This issue of the Bulletin is being prepared as Thanksgiving approaches. Even though your copy will not arrive until the great American holiday is past, it seems an appropriate time to thank all who have helped us, either as individuals or as a group, during the past year. Among those to whom we owe special gratitude, the following come readily to mind:

All who shared in providing hospitality for our regular meetings—some by helping with the refreshments, others with the entertainment, and still others by making available our places of meeting;

Any and all who turned a sympathetic ear to our plea for architectural modifications making it possible for those in wheel chairs to get in and

out of public buildings, educational institutions, and places of entertainment;

Our respective employers, who disregarded or overcame whatever misgivings they may have had in regard to hiring a handicapped person, and who thereby gave us a chance to become self-supporting, productive members of society.

The doctors, nurses, therapists, and counselors who brought all their skill and patience to bear in seeking solutions to our problems, often going beyond the bounds of duty that we might attain the fullest use of our capacities;

The innumerable people, known and unknown, who extended a helping hand when we needed it, including our personal friends and loved ones as well as passers-by, strangers on the street and highway, policemen, clerks, maids, janitors, and others;

And last, our families, friends and associates, who cheerfully inconvenience themselves for our comfort and pleasure, who put up with our moments of depression and irritability, and who motivate us in turn to live as usefully and as constructively as lies within our power.

To all these we say a heartfelt thank you. And may we remember not to confine our gratitude to one day in the year, but to make each day one of thanksgiving and praise.

* * *

BROTHERHOOD WEEK

One of the most important of the many worthy organizations in this country is the National Conference of Christians and Jews, which was founded in 1928 to combat all forms of bigotry. It has grown steadily from a handful of dedicated citizens to a nationwide educational program with 150 chapters. Since 1934 this Conference has sponsored Brotherhood Week. This year nearly 10,000 communities will participate in programs during Brotherhood Week February 19-26.

The observance, which is not a fund-raising campaign, has for its purpose:

1. Rededication to the basic ideals of respect for individuals and peoples.
2. Practical steps which people can take to promote an understanding and realization of these ideals.
3. Enlistment of people in year-around activities to build brotherhood.

President's Message

THE DECISION IS YOURS

On page 36 of this issue you will find a concise summary of the action taken by your Executive Council relative to implementing that portion of the Kerr-Mills Act which is designed to supply medical assistance to the aging. This summary is in the form of a letter written by Dr. John R. Kernodle, chairman of the Committee on Chronic Illness to Dr. Ellen Winston, Commissioner of Public Welfare State of North Carolina, whose Department of Public Welfare will administer the Act. A copy of the letter was submitted by Dr. Kernodle for publication in this JOURNAL.

It is of utmost importance that every member of this Society understand clearly the intents and purposes of this Act. An awareness of some of the mechanics of implementing this law is necessary if you are to follow intelligently and approve or disapprove the actions taken by your Executive Council. Our final decision and subsequent action must reflect an intelligent decision as to what method will best supply excellent medical care to this segment of North Carolina's citizens. Lastly, as doctors and citizens we must stand united to a single man as regards our course of action.

Let me say personally that it is with considerable misgivings that I acquiesce to this principle and method of supplying medical care for the needy. To me, it is still basic that the responsibility remain, in order, with the family, the community and the area, and only after these resource areas have been unable to meet this responsibility should the state and federal government be called in. It is fundamentally true that the Act provides a maximum of federal funds for its financial implementation with a minimum of federal regulations to govern its usage. However, the mechanics for unlimited state governmental control and regulation is built into the Act. The Act is implemented in North Carolina financially, but without specific "ground rules," and restrictions, as spelled out elsewhere in this JOURNAL, could in effect put the Department of Public Wel-

fare of this state in the unlimited practice of medicine for the entire age group above 65. If the ultimate result of cooperation with any plan or enabling act is *state medicine*, it then makes very little difference whether the facilities designed to accomplish this end were brought forth from Washington or from Raleigh.

The American Medical Association, and subsequently your Executive Council, on two separate sittings have affirmed that we should support and work with this Act within the limit that it supply excellent medical care for those people aged 65 or older who exhibit definite financial need. Already, medicine is cooperating with this Act in several states. Many states, like North Carolina, are in the process of implementation. I know of no State Medical Society flatly refusing to cooperate. Therefore, assuming that, under reasonable circumstances, we too will be cooperative, let us move to a fundamental understanding of the proposition at hand.

The Kerr-Mills Act is pertinent to medicine chiefly under Title 6, which had the active support of the American Medical Association. Title 6 does two things: (1) Amends the Old Age Assistance Program (hereafter OAA) to provide an increase in federal matching funds for those states which have vendor medical care programs; (2) establishes a new program of medical assistance for members of our aged population not receiving OAA benefits (hereafter MAA).

With one reference to the OAA program we can dismiss it from consideration. Recognizing that the 80 per cent federal matching funds come from general federal tax funds, your Executive Council "authorized the participation of medical doctors in vendor payment for medical services to OAA recipients, inclusive of the categories ADC - ATPD - and AB."

Our major concern in North Carolina deals chiefly with implementing the second portion of Title 6 dealing with MAA. In this

consideration I will draw heavily from AMA literature.

With respect to the scope of benefits under the MAA program, the only limit is a *minimum level*—the state plan must provide for the inclusion of *some* institutional and *some* non-institutional care and services. There is no limit, however, on *how much* or *how many* services may be included. The law provides a list, which I am sure you have seen: inpatient hospital or clinic services; home health care services; private duty nursing services; physical therapy and related services; dental services, laboratory and X-ray services; prescribed drugs, eyeglasses, dentures, and prosthetic devices; diagnostic, screening and preventive services; and (just in case anything was missed) the law also authorizes any other medical care or remedial care recognized under state law.

The above quotation makes it self-evident that without a system of priorities and controls, the "sky is the limit" as to where we could go with services to this age group. Therefore, the Executive Council has established suggestions regarding priorities and limitations of services to be available (catalogued elsewhere in this issue).

While the Kerr-Mills Act leaves most of the implementary legislation to be accomplished at a state level, yet there are certain broad federal requirements, listed below, whose interpretation could impose considerable federal control:

1. That no enrollment fee or similar charge will be imposed as a condition of eligibility.
2. For the furnishing of assistance to residents of the state even though they are temporarily absent.
3. *Reasonable* standards for determining eligibility for and the extent of such assistance.
4. That no lien will be imposed on the property of the individual prior to his death and that there will be no recovery until after the death of such individual and his surviving spouse, if any, for any medical assistance correctly paid on behalf of such individual.

While there are two programs, the law specifically provides that it is not to be construed to permit a state to have more than one plan for the aged. In other words, both programs have to be administered by the

same agency. This does not mean, however, that if the program were administered by the state department of public welfare it could not contract with the department of health, a medical society, Blue Shield or some other agency to carry out the medical care program.

Your Executive Council thought that these broad areas should be bounded by specific recommendations and "ground rules." This comprises a major portion of the actions of the council as relayed to Dr. Winston in Dr. Kernodle's letter elsewhere in this issue.

In summary, therefore, you can see that just about the only limitation on the scope of the new MAA program is that only those persons over 65 years of age and not on Old Age Assistance are eligible. Aside from that, there is *no limit* on what medical, paramedical, or remedial services can be paid for, *no limit* on what mechanisms can be used to channel payments to the providers of care except that *over-all* responsibility must be in the hands of the Department of Public Welfare, the same agency that administers OAA, and *no real limit* on which of the aged can be considered eligible. To the extent that limits do exist, they must be set by the individual states. What MAA means in your state, therefore, depends pretty much on what you as individual physicians who will supply most of the services mean, and what your state wants it to mean.

On January 29, 1961, a few days after this information should be available to you, your Executive Council will again meet in Pinehurst. A main item of the agenda will be to consider further the implementation of this Act in the light of what transpires from November 28, 1960, to January 29, 1961. All members of this society have the right and the duty to express their personal convictions to the council on this day, either through personal contact with their individual district councilor or through personal representation before the council in session on that day. Be informed—be participant—or else be forever silent. THE DECISION IS YOURS.

AMOS N. JOHNSON, M.D.

Committees & Organizations

COMMITTEE ON CHRONIC ILLNESS

IMPLEMENTATION OF THE KERR-MILLS ACT

The following letter from Dr. John R. Kernodle, Chairman of the Committee on Chronic Illness, to Dr. Ellen Winston, Commissioner of Public Welfare of the State of North Carolina, represents a summary of the specific actions taken by the Executive Council of the Medical Society of the State of North Carolina in session in Pinehurst, North Carolina, November 28, 1960.

This summary consists of recommendations to the Department of Public Welfare and the Advisory Budget Committee setting out the terms and conditions constituting the "ground rules" under which this Society would participate in the implementation of this Act.

December 7, 1960

Dr. Ellen Winston
Commissioner of Public Welfare
Raleigh, North Carolina

Dear Dr. Winston:

As authorized by the Executive Council on October 2, 1960, and reiterated on November 28, 1960, I have the duty to report to you upon actions of the Executive Council of the Medical Society of the State of North Carolina upon its consideration of the provisions of the Public Law 86-778 constituting revisions to the Federal Social Security Act, and particularly to that measure known as the Kerr-Mills Act enacted by the 86th Congress. It may be assumed that the Society reports as an organization and not specifically for individual members where such member may exercise a personal right of interest and function under the law.

A. As a preamble the Society strongly recommends the following considerations in formulating a plan.

1. That provision for medical services should include only physicians and dentists.
2. That a factor of deductible medical care be incorporated in the plan in the form of payments made by apply-

ing individual for a certain amount of purchased medical care within the one year of application for services under the plan, such amount to be determined on recommendation of the Medical Society on negotiation with the state agency and be required to have been paid by the individual within the year as a condition of eligibility for services under the plan.

3. That the written plan implementing medical assistance under PL 86-778 should have a broad base and that the plan and program providing actual and specific medical services be prepared, arranged and regularly evaluated by a Committee for the Medical Care of the Aged, the membership of which would include all the disciplines involved in a recognized medical assistance program, upon which basis a greater preponderance should be doctors of medicine.
4. That such a program of medical assistance will be accepted by the Medical Society with the understanding that it will have the opportunity to withdraw from participation after due notice to the appropriate administrative agency; that all future changes of rules, plans and the addition of new services encompassed in the plan will be duly evaluated and accepted as a negotiated arrangement of service by the Medical Society of the State of North Carolina based on information exchanged by the agency and the Society as to changes in operation or expansion of the plan; that recognizing the necessity of close association in developing and operating the plan, the Society will be given an opportunity to annually evaluate and report to the agency on the plan through the appropriate committee of the Society.
- B. Upon the above expressions and understandings the Executive Council of the Medical Society adopted the following recommendations to the agency or agencies of the State of North Carolina charged either by legislation or executive di-

rection with the development and operation of the services and the administration of the plan to be established under PL 86-778:

1. The Executive Council reaffirms its decision to cooperate in the implementation of PL 86-778.
 2. The Executive Council requests that vendor payments for medical services performed be made to medical doctors under the Medical Assistance to the Aged program (MAA).
 3. The Executive Council authorizes the participation of medical doctors in vendor payments for medical services to Old Age Assistance recipients (OAA), inclusive of the categories (ADC, ATPD, and AB).
 4. That the Executive Council recommends and endorses the establishment of the institutional phase of the Medical Assistance to the Aged in the form of hospitalization as priority I.
 5. That medical doctor services be compensated on a vendor payment basis according to a schedule of fees which is to be developed on committee assignment and to be reported in detail to the Executive Council for consideration and action January 29, 1961; and that for the purpose of making budgetary estimates by the State, a compensation for basic medical service be recognized at three dollars (\$3.00) for office visit; five dollars (\$5.00) for home visit; seven dollars and fifty cents (\$7.50) for night visits and that special consideration be given to reports of services involving unusual mileage in attending or for prolonged and necessary detention in attending patients on home visits.
 6. The Executive Council recommends that the following non-institutional services be included in the plan:
 - a. Home and office medical doctor visits.
 - b. Dental care services of dentists.
 - c. Drugs.
 - d. Special procedure medical techniques such as Laboratory, X-Ray and physiotherapy services, injection drugs given in the office of the medical doctor; X-Ray, Laboratory and physiotherapy given to patients that are not in the hospital as hospital patients, but as an out-patient directed to the hospital by a doctor in whose office those facilities are not available.
- Each of these priorities listed a, b, c, and d should have equal consideration and each is considered essential to the operation of the plan.
7. In consideration of eligibility requirements for persons applying for medical assistance services under the plan the Executive Council recommends a standing level of eligibility involving three factors, each of which must be met as a condition of eligibility offered by the applicant to wit:
 - a. That the annual income does not exceed one thousand dollars (\$1,000) per person or two thousand (\$2,000) per couple.
 - b. That the net worth per person or per couple of all property real or personal does not exceed seven thousand five hundred dollars (\$7,500).
 - c. That the liquid assets per person or per couple does not exceed one thousand dollars (\$1,000).
- Provided, however, that special consideration may be given to unusual hardship situations with approval of the Committee established as recommended under item A-3 above.
- It is hereby reiterated that the proposals herein recommended are not final and that same is subject to review and revisal as a proposition prior to the date of January 29, 1961.
- Respectfully submitted,
John R. Kernodle, M.D., Chairman
Committee on Chronic Illness
Medical Society of the State of
North Carolina

Correspondence

AMERICAN SOCIETY OF CLINICAL RADIOLOGY

To the Editor:

Several months ago, the American College of Radiology received inquiries from many editors of state and other medical society journals relative to the American Society of Diagnostic Radiology which was then being promoted by Dr. Louis Shattuck Baer, a California internist. Correspondence with Doctor Baer revealed that that society had no Constitution, Bylaws or officers. The aims of the society were variously described in different communications.

More recently, the College has received inquiries relative to the American Society of Clinical Radiology, also being promoted by Dr. Louis Shattuck Baer. The College takes this means of notifying you that this organization has no known connection with any radiological society or group. Further, it is the opinion of the College:

1. That sufficient opportunities exist in the meetings of county, state, regional and national medical societies for the presentation of worthwhile papers and exhibits in the field of radiology.
2. That sufficient special and general medical journals now exist for the publication of meritorious medical and scientific communications in the field of radiology.
3. That the use of the term, radiology, in the title of an organization may unfortunately cause those not informed to identify this group as being composed of physicians who have been examined and certified to be competent in radiology by a recognized medical specialty board.
4. That medical journals and their sponsoring medical societies would be well advised to obtain full details concerning the American Society of Clinical Radiology before soliciting reader-members on behalf of Doctor Baer.

THE AMERICAN COLLEGE OF RADIOLOGY

Bulletin Board

COMING MEETINGS

Duke University Medical Center, Lectures on Ophthalmology—Eye Clinic, Duke Hospital, Tuesday evenings, 7:30 p.m.

University of North Carolina School of Medicine, Postgraduate Course in Medicine—Edenton, Wednesdays, beginning January 11; Kinston, Thursdays, beginning January 12.

Governor's Conference on Occupational Health—Raleigh, January 26.

Conference of North Carolina County Medical Society Officers and Committee Members—Pinehurst, January 28.

Watts Hospital Symposium—Durham, February 3-4.

North Carolina Mental Health Association, Annual Meeting—Raleigh, February 17-18.

Forsyth County Cancer Symposium—Winston-Salem, March 9.

Medical Society of the State of North Carolina, Annual Meeting—Asheville, May 6-10.

Southeastern Surgical Association—Deauville Hotel, Miami Beach, Florida, March 6-9.

New Orleans Graduate Medical Assembly—Roosevelt Hotel, New Orleans, March 6-9.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

The Duke University Medical Center recently announced the organization of muscular dystrophy clinics for both children and adults.

According to Dr. Jerome S. Harris, professor of pediatrics and chairman of the department, who is one of three physicians in charge of the clinics, arrangements have been worked out in cooperation with the Muscular Dystrophy Associations of America and its newly formed Durham-Raleigh Area Chapter.

Other Duke physicians who will direct the clinics are Dr. E. Charles Kunkle, professor of neurology; and Dr. Albert Heyman, associate professor of neurology.

While acknowledging that as yet there is no definitive treatment for muscular dystrophy, Dr. Harris explained: "The purpose of this program will be to provide clinic and hospital facilities for the diagnosis, care and rehabilitation of patients with muscular dystrophy."

He said the clinics will be operated on an appointment basis, and that appointments may be made by calling Duke University, Extension 2411.

* * *

A grant of \$8,396 has been made to Duke University by the Department of Health, Education and Welfare to support study of the physical therapist's role in relation to surgery.

Being conducted in the Duke Medical Center's physical therapy department, the project deals with investigation of new methods of treatment, evaluation of present procedures and development of suitable ways of teaching the results to physical therapy and medical students.

ROBESON COUNTY MEDICAL SOCIETY

The Robeson County Medical Society held its annual Christmas Party and Ladies Night December 5, 1960, at the Pine Crest Country Club. There were 94, doctors, wives, and guests present.

Mr. Edmund Hardin, Washington, North Carolina, gave a humorous and entertaining after-dinner address.

Dr. Jack E. Dunlap, orthopedic surgeon, was accepted for membership in the society.

EDGECOMBE-NASH MEDICAL SOCIETY

The Edgecombe-Nash Medical Society held its regular monthly supper meeting in Rocky Mount on December 13.

The program consisted of the yearly election of officers.

THE NATIONAL FOUNDATION

The state of North Carolina has been the principal beneficiary in the allocation of March of Dimes funds in the state over the past 23 years, it was disclosed recently in a financial summary prepared by The National Foundation.

More than 88 cents of every dollar from North Carolina's March of Dimes has been put to use in aiding the state's disease victims and in research and education projects conducted by North Carolina institutions. Of the remaining 12 per cent accruing to the national headquarters, a considerable amount also has come back to North Carolina in shipments of polio vaccine and gamma globulin, and in other nationwide services conducted by The National Foundation.

The summary covers the period since the first March of Dimes was held in January, 1938, and compares the net total of funds raised in the state with amounts made available to North Carolina through September 30, 1960.

In this period, North Carolina chapters of the March of Dimes organization raised a net total of \$13,547,058.66 at an average fund-raising cost of less than 5½ per cent. Of this amount, \$10,642,656.99 has been available to the county chapters in carrying out their extensive patient aid programs, including advances of \$4,945,457.08 from the national office to meet local emergency situations.

In addition, 51 grants totaling \$1,253,712.13 have been made in support of research and professional education projects at North Carolina institutions. Principal recipients of these grants have been

Duke University \$705,318.85,
The University of North Carolina \$345,740.82,
North Carolina College at Durham \$112,312.05,
Bowman-Gray School of Medicine
of Wake Forest College \$ 90,340.41

Over and above the 88 per cent used by institutions and county chapters in the state, The National Foundation has financed within the state projects such as the historic field trials which proved the effectiveness of the Salk vaccine, epidemiological studies, and scholarship or fellowship grants to North Carolina residents. National headquarters' expenditures for the vaccine trials in North Carolina amounted to \$23,420.98. In addition, the national office has sent into North Carolina \$134,410.85 worth of Salk vaccine and 278,886 cc. of gamma globulin in support of its polio prevention programs.

Two years ago, the National Foundation for Infantile Paralysis changed its name to The National Foundation in expanding its areas of interest beyond polio to include birth defects and arthritis, using the scientific knowledge and experience gained in the fight against polio.

The New March of Dimes takes place throughout the month of January.

FIFTH ILLINOIS CONGRESS ON MATERNAL AND INFANT HEALTH

"Science, Service, and Sentiment of Modern Maternal and Infant Health" will be the theme of the Fifth Illinois Congress on Maternal and Infant Health, to be held at the St. Nicholas Hotel, Springfield, Illinois, February 8-10. This Congress will offer breakfast and luncheon conferences, round tables, and formal papers designed to enable maximum participation in group discussion.

Address requests for program and registration forms to the Illinois Committee on Maternal and Infant Health, American Association for Maternal and Infant Health, 116 South Michigan Avenue, Chicago 3, Illinois.

AMERICAN COLLEGE OF GASTROENTEROLOGY

Dr. Louis Ochs, Jr., associate professor of medicine, Louisiana State University School of medicine, was chosen as president-elect of the American College of Gastroenterology, at the annual meeting of the College, held Sunday, October 23, 1960, in Philadelphia. He will assume the presidency at the next annual meeting, to be held in Cleveland, Ohio, in October of 1961.

Dr. Henry Baker of Boston, Massachusetts, selected president-elect in Los Angeles in 1959, assumed the presidency of the College at the Annual Dinner-Dance held on October 25, 1960. He succeeded Dr. Joseph Shaiken of Milwaukee, Wisconsin, who became chairman of the Board of Trustees.

THE DEAFNESS RESEARCH FOUNDATION

Five Temporal Bone Banks to forward research in loss of hearing, have been established in major universities in the United States by the Deafness Research Foundation since June 30, 1960, it was announced recently by Mrs. Hobart C. Ramsey, founder and president.

Located at Columbia University College of Physicians and Surgeons, New York University Medical Center, Johns Hopkins University School of Medicine, University of Chicago, and the University of Michigan, the banks are directed by the Chiefs of Staff of the Departments of Otolaryngology.

The Temporal Bone Banks, unlike the Eye Banks, are for basic research rather than for transplants. In laboratories throughout the country, inner ear findings will be correlated with the examination of the patient's history and records. This will determine pathologic conditions that accompany such types of deafness as Meniere's disease, otosclerosis, labyrinthitis, as well as deafness due to other causes.

These banks, the first in medical history to be formed on a national scale in any country, were made possible by donors including the Doris Duke Foundation, the McGregor Fund, and the Lillia Babbitt Hyde Foundation.

The Deafness Research Foundation, incorporated in January, 1958, is the first national voluntary organization devoted to sponsoring research in the field of hearing, and to developing greater public awareness of the problems of deafness. Headquarters are at 310 Lexington Avenue, New York 16, New York.

INTERNATIONAL NURSING HOME CENTER

The Nation's Capital will boast another important addition to its galaxy of famed buildings. This one will be the International Nursing Home, Research, Educational, and Service Center.

Although there are nearly 14,000 licensed nursing homes and another 10,000 bed-and-board homes operating throughout 50 states, these provide only about 450,000 beds, or, one for every four aged or infirm people. In order to provide one skilled nursing home bed for every four elderly people by 1975, more than 1,000,000 new beds and facilities will have to be constructed at a cost of more than 5 billion dollars.

One of the major solutions to this problem will come from the new 11-million dollar center due for construction in Washington, D. C. in 1961.

The Center will be a base of operations for all nursing home administrators from all over the country. It will have a school to train administrators and nursing home personnel, one of the world's largest libraries on care for the aging and chronically ill, a model nursing home fully equipped and operating, a permanent display of

nursing home equipment, as well as extensive research facilities.

The entire cost of this 11 million dollar project will come from private financing, donations, and grants. Already Mutual of Omaha has given \$80,000 toward it. Other insurance companies and pharmaceutical firms are interested in helping.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The next scheduled examinations (Part II), oral and clinical for all candidates, will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board April 8 through 15, 1961. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I Examinations will be notified of their eligibility for the Part II Examinations as soon as possible.

The deadline date for the receipt of new and reopened applications for the 1962 examinations is August the first, 1961. Candidates are urged to submit their applications as soon as possible before that time.

Robert L. Faulkner, M.D.
2105 Adelbert Road
Cleveland 6, Ohio

VETERANS ADMINISTRATION

The Veterans Administration opened its eleventh day care center for mental patients recently at Baltimore, Maryland.

The centers are one of the newer developments in psychiatry. Other VA day care centers are located in Washington, D. C., Philadelphia, Brooklyn, New York City, Boston, San Diego, Los Angeles, San Francisco, Providence, R. I., and Chicago (VA West Side Hospital).

* * *

Major advances are being made in reducing re-hospitalization rates of Veterans Administration mental patients, through cooperation of hospitals and community vocational and employment services.

Dr. Robert S. Waldrop, director of vocational counseling for the VA Department of Medicine and Surgery in Washington, D. C., said VA hospitals where patients receive these intensive preparatory and follow-up services have reported re-admission rates as low as 12 per cent, as compared with the 50 per cent rate for mental hospitals in the United States generally.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

About two-thirds of the civilian non-institutional population of the United States had some form of voluntary health insurance during the last half of 1959, according to a new report just

published by the Public Health Service's U. S. National Health Survey.

The figures show that about 67 per cent of the civilian non-institutional population had some hospital insurance, 62 per cent was reported to have surgical insurance, and 19 per cent to have insurance against the cost of physician visits at home or in the doctor's office. They do not indicate whether the insurance paid the entire bills or only parts of them.

AMERICAN ACADEMY OF GENERAL PRACTICE

William R. DeLay, former press relations manager of Mead Johnson & Company, has joined the American Academy of General Practice as assistant for public relations, Mac F. Cahal, executive director of the Academy, announced recently.

Mr. Cahal said Mr. DeLay will be responsible for developing and executing a formal program of public relations activities for the Academy, the nation's second largest medical association. Among his major duties will be maintaining and furthering the Academy's relations with the press.

Special Menus, Recipes Prepared for Cholesterol Depressant Regimen

An easy-to-use manual of diet instructions available for professional distribution only has been prepared for use by physicians in the treatment of patients with elevated serum cholesterol, according to a recent announcement by Wesson.

The manual presents menus, recipes, shopping and cooking guidance, arranged according to levels of 1,200, 1,800 and 2,600 calories so that the physician need only check the desired daily calorie level before giving the book to the patient. Complete menus for 10 days, with a total of 70 recipes, are included. They provide prescribed levels of calories, the pre-determined ratio of poly-unsaturated to saturated fat, and the essential nutrients which are recommended by the Food and Nutrition Board of the National Research Council.

Available exclusively to the medical profession and the American Dietetic Association, the manual is acceptable for use with diabetics. Carbohydrates have been calculated to fall within the acceptable range for patients to whom a diet planned for diabetes is important.

Physicians and dietitians may obtain multiple copies of "Your Cholesterol Depressant Diet Cook Book" at no cost, by writing to The Wesson People, 210 Baronne St., New Orleans 12, La.

Women usually live longer than men in this country, and the relative difference has increased steadily since 1900. The average girl born in 1958 could expect to live 72.7 years, or 6.3 years longer than the 66.4 life expectancy for boys.—Health Information Foundation.

The Month in Washington

Physicians are being urged to cooperate fully to get their states to participate as soon as possible in the new federal-state program for medical care of needy and the near-needy older persons.

The medical profession also has been alerted to the dangers of relaxing its opposition to tying in medical care of the aged with Social Security. It is probable that the Kennedy Administration will try in 1961 to get Congressional approval of such legislation.

E. Vincent Askey, M.D., President of the American Medical Association, pointed out to the recent Washington meeting of the A.M.A. House of Delegates that proponents of the Social Security approach had a pledge of support from the successful Democratic candidate for President.

"While our profession clearly may face a hard struggle in the Eighty-seventh Congress on the issue of medical aid for the aged under Social Security, there is no ground for defeatism!" Dr. Askey said.

"Our cause is far from lost. We know that our policy position is in the best interests of all Americans, the aged included, and our willingness to defend this policy must be strengthened and maintained."

Dr. Askey reminded the House of Delegates that "medicine has many friends in both parties in Congress today."

A few days later, Senator Harry F. Byrd (D., Va.), chairman of the Senate Finance Committee which handles Social Security legislation, reiterated his opposition to a compulsory medical care plan under Social Security. He said:

"I am opposed to the [Democratic party] platform recommendation for compulsory medical service and hospitalization under the Social Security system. I am convinced this would lead to socialized medicine with the possibility that it would bankrupt the Social Security trust fund. This matter came before the Finance Committee and was fought out in the post-convention session of

From the Washington Office of the American Medical Association, 1523 L Street, N. W.

Congress last August. The Senate voted 51 to 44 in opposition to the Democratic platform proposal, and instead adopted a fair plan for medical service and hospitalization for those in need of it."

Dr. Askey urged that all county and state medical associations provide "the medical leadership necessary to implement the Mills-Kerr bill (the new federal-state program) as rapidly as possible." And the House of Delegates adopted such a resolution.

"We must put forth a sincere and concentrated effort during the coming year to make the Mills-Kerr law effective, to show that it can, practically as well as potentially, solve the problem of medical care for the aged," Dr. Askey said.

President-elect John F. Kennedy's first Cabinet appointment was Governor Abraham Ribicoff of Connecticut as Secretary of Health, Education and Welfare—the official with primary responsibility for carrying out the federal part of the Mills-Kerr program.

Ribicoff, 50, was an early supporter of Kennedy for the Presidential nomination. He was twice elected governor of Connecticut. Before that, he served as a Hartford, Connecticut, police judge, a member of the state legislature and a member of the national House of Representatives. As governor, he inaugurated a comprehensive traffic safety program with strong penalties.

* * *

The Sabin oral polio vaccine will not be available in sufficient quantity in 1961 for large scale use.

Leroy E. Burney, M.D., Surgeon General of the U. S. Public Health Service, told the recent Clinical Meeting of the A.M.A. that many problems involved in taking the oral vaccine out of the laboratory and into mass production had not been solved.

In light of this fact, both the A.M.A. House of Delegates and Dr. Burney urged that the widest possible use of the Salk vaccine be encouraged. Dr. Burney said that large numbers of the U. S. population, including almost half of the children under 5, had not been fully vaccinated with the effective Salk vaccine.

Dr. Burney said the problems of integrating the oral vaccine into the present program of immunization against polio "are many and complex."

"Only the future can tell whether control of poliomyelitis will be accomplished through a live, orally administered vaccine, the killed vaccine, or a combination of both," Dr. Burney said.

* * *

The Food and Drug Administration issued stricter rules, some effective January 8 and others effective March 9, governing promotion and marketing of prescription drugs. The new regulations are designed to insure safe use of the drugs.

Under the new regulations, manufacturers must disclose hazards, as well as advantages, of the drugs in promotional material sent to physicians. Manufacturers can be denied permission to market drugs they refuse to permit FDA inspection of manufacturing methods, facilities, controls or records.

The FDA deferred until later action on its proposal to require every package of drugs sold to pharmacies to contain an official brochure on their use and hazards. The A.M.A. proposed instead that it be given the responsibility of getting such information directly to physicians.

* * *

Foreign interns who failed medical examinations last September may remain in this country until at least next July 1.

In cooperation with the State Department, the A.M.A. agreed to extend for six months a January 1 deadline for dismissal of foreign interns unless they pass the examinations through the Educational Council for Foreign Medical Graduates.

The flunking interns will be given another opportunity to take the examinations in April. Meantime, they must be taken off patient care and their hospitals must set up training programs for them.

The A.M.A. Council on Medical Education and Hospitals, said that this policy would be carried out judiciously and that occasional exceptions would be granted where circumstances warranted.

Book Review

Social and Medical Problems of the Elderly. By Kenneth Hazell, MRCP, MRCPE, DPM. 216 pages. Price, 30s net. London: Hutchinson Medical Publications, 1960.

The content of this little book is well described in its title. The author evidently writes from first-hand knowledge of older people as individuals. All through the book Dr. Hazell shows his sympathetic understanding of the elderly, especially the ones who are in the low-income bracket.

The first chapter is devoted to social considerations. Then hospital service, including a geriatric unit and out-patient department, is discussed, and many practical suggestions are offered. A long chapter on special medical problems in the elderly compresses a great deal of information covering a wide range. Home treatment is discussed in some detail. The author's sympathetic understanding is shown by such expressions as, "One of the most serious hardships for the elderly is loneliness . . . continued loneliness brings about not only mental illness but also physical illness . . . the physical ill health worsens the mental state and *vice versa*, so setting up a vicious circle of poor general health."

It is somewhat of a digression to point out the possible importance of a comma. On page 50 there is a sentence, "The next type of case may be an elderly lady with a fractured femur, which is considered inoperable." This would leave the impression that a fractured femur is a condition which is always inoperable. On page 149, however, the author says, "Many patients of ninety years and over have been successfully pinned, and age alone is no bar to this procedure."

Dr. Hazell obviously is not enthusiastic about the National Health Service nor about the extremes to which the welfare state has gone in Great Britain. He thinks that the older people are having a much harder time than are the younger: "The younger age groups have all the benefits of the welfare state at the expense of those on fixed incomes, that is to say, the old age pensioner . . . The key question is: Does the cost of the welfare state cause inflation? If the answer is that it does, then it is worth giving some thought as to how it will affect those on fixed incomes, particularly the elderly pensioner who is unemployed. It looks very much as if the thrifty are penalized and the spendthrift supported, but both are at the mercy of the disputes between the trade unions and big employers. The former are always trying for higher wages and the latter for better profits, and it is the pensioner who is the casualty in this struggle."

While Dr. Hazell's book is written from the

British standpoint and some of it would not apply to this country, it has so much sound and comprehensive information about the older population that it can be heartily recommended to any interested in this age group.

In Memoriam

Reno Kirby Farrington, M.D.

The untimely death of Dr. Reno Kirby Farrington, on April 28, 1960, at the age of 59 years, was a shock and tragic loss to the Davidson County Medical Society. The members of the Society herewith express their personal respect for their co-worker, their appreciation of his friendship, and grief at his passing.

Kirby Farrington served his community well as physician and friend. Its welfare was vital to his heart. Through the years he loyally served in any capacity the community or its organizations requested. This town was his home; he loved it, and the people in it were dear to him. He shared in the joys that came to those about him, and was joyfully present at weddings, receptions, and all public and private social functions. We have seen him eat and laugh heartily at family reunions and other gatherings throughout Davidson County. When grief came to those of our town, he was there with the sympathy and strength which his way, height and figure seemed to give to those about him. Deep and widespread was the love of the people for Kirby, and his passing will long be mourned by "Our Town."

Dr. Farrington was one of those who worked to bring about the founding of City Memorial Hospital, in Thomasville, and in the early years worked diligently to locate and find good nursing personnel to serve here. There are still nurses of this area who were led to come here to serve by him, and who still render nursing service to this area. He was always actively concerned and constantly in pursuit of better hospital facilities and efficient personnel to staff the hospital. He was ready to support new ideas, new methods, and new proposals that would enhance the efficiency of the medical service of this hospital. The hospital itself is, in part, a memorial to him.

Dr. Farrington was vitally interested in the young physicians who came to Thomasville to practice. He offered his friendship and advice, stood by them when he was needed, and served them well when his advice and help was desired. His surgical abilities and special aptitudes in the profession were recognized by all of us, and are sorely missed.

The vital color and personality of Kirby Farrington was a constant source of daily pleasure and confidence to those of us who worked with him day by day in the medical profession. His will to carry on professionally through the past

18 years, in spite of impairment of his heart, was ever a source of inspiration to us. Sometimes we feared for his physical welfare, but his sanity and courage in continuing to serve his family and community was a source of power to those who worked beside him. He was the best adjusted man to his physical impairment that we have ever known, and this in itself was a source of strength to those who knew him.

To Dr. Farrington's family we express our sympathy in this loss. We mourn with them and offer our services to them in the days and years ahead in any way that they may find reason to use them. With them, we loved him.

V. H. Duckett, M.D.

May 3, 1902 - October 25, 1960

In the physical departure of Dr. V. H. Duckett not only Canton and Haywood County, North Carolina, but the ever-expanding communities experience the passing of a great man and good physician. What he was and what he did will forever remain a part of the earthly society which he relished.

The departed, perhaps above all, would like to be remembered as a good doctor. That he was. Well trained and always in process of training, he kept abreast the science of medicine. A lover of people, he matured in the art of medicine. The patient, once regarding him as abrupt, re-

turned to find him objective, deeply interested, and as lovingly willing to attack a behavior as a physical problem.

The good physician would like to be remembered as a good citizen. All phases of society stand witness to this desire.

He was vestryman in his church, repeatedly a committeeman for the Y.M.C.A. Religious Week, and an appreciative Mason. He remained a consistent supporter of religious education locally and in church-related colleges.

He was organizer and first president of the Canton Lions Club. For more than 16 years he maintained a perfect attendance record, always present at meetings except when confined by illness or engaged in civic activities accredited to Lionism.

He was a promoter and an early and outstanding president of the North Carolina Chapter of the American Academy of General Practice. In this organization he remained a guiding light.

A champion of organized medicine, he served in every capacity including the presidency of the Haywood County Medical Society. He remained active in the affairs of the North Carolina Medical Society, the American Medical Association, and the Southern Medical Association. A railroad surgeon and an affiliate with Champion Paper and Fiber Company, he kept informed in the problems of the laborer.

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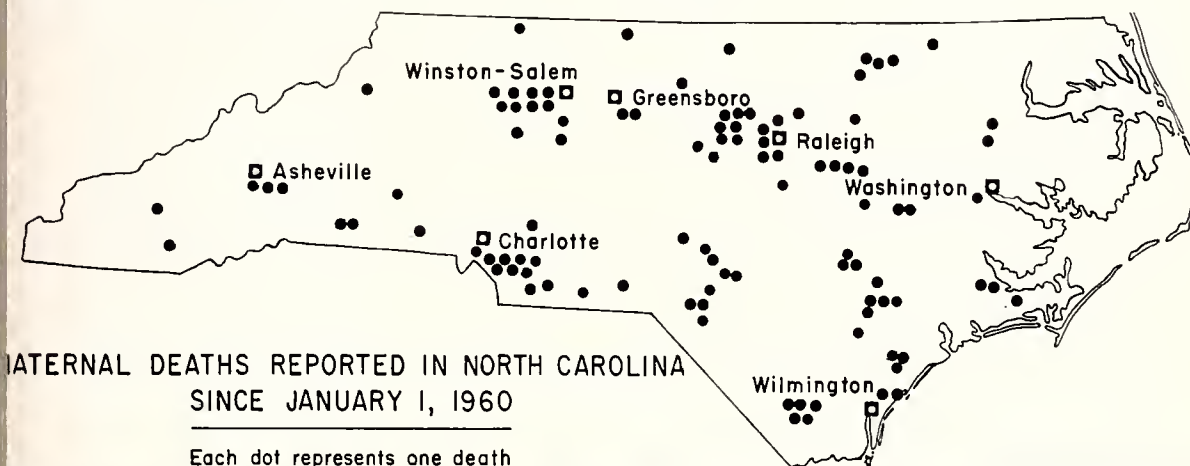
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A strong supporter of public education, he persisted in his interest in enrichment as well as expansion of the educational program. Almost single-handedly, he initiated and organized the Canton High School Band and through the years found ways and means of reasonably adequate financial support for this organization. He persisted in his plea for more teachers, more guidance personnel, more fine arts opportunities, and more money to secure these objectives.

Dr. V. H. Duckett, the good citizen, was too humble and self-searching to think of being regarded as a great and good man. Even so, those

who knew him best will regard him first of all as great and good.

For a long period invalid and then semi-invalid, he attained a religious adjustment to life. He persistently felt everywhere and always at home in the universe. His sense of humor was so healthy that he laughed best at himself and his own limitations. Not perfect, as none but his Savior was perfect, he above all could see his imperfections. He loved life and regarded death as a part of the process of life. He no more feared death than he did the life he loved and lived so fully.



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1. Rubin, W., and Anderson, J. R.: Angiology 9:256, 1958.

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IN THIS ISSUE:

Run-over Accidents

Eben Alexander, Jr., M. D., and Others

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Run-over (Überfahren) Accidents

EBEN ALEXANDER, JR., M. D.

RICHARD T. MYERS, M. D.

and

COURTLAND H. DAVIS, JR., M. D.

WINSTON-SALEM

In a broad review of run-over accidents in the German, Dutch, French, Italian, English, and American literature, the past reports are primarily those of fatal injuries. Many of them—particularly the head injuries—are of medicolegal interest.

The present report of 11 cases is concerned with clinical patients. Some of them received severe injuries. Many, however, showed dramatic changes in the skin immediately after the accident which quickly disappeared, and the patients rapidly returned to normal.

The astounding conclusion is that relatively reversible injury may result when the pneumatic tire of a slowly moving vehicle passes over the head, chest, or another part of the body of a small child lying on a hard surface, leaving tire tread marks on the skin.

Little investigation has been made of the amount of compression which can be tolerated by the human body. Studies of acceleration and deceleration have shown that the human body can withstand tremendous pressure for brief periods of time, but this is broadly exerted over large portions of the body rather than the localized pressure which comes from run-over accidents. De Haven¹ and others in conjunction with the Air Force investigated the effects

of acceleration and deceleration, and they found that human beings can withstand powerful pressure for a short time.

Case Reports

Case 1

On May 1, 1950, a 2 year old child was playing in a driveway. As a 1950 Buick convertible sedan backed out of the driveway, her head became caught under the wheel. Marks showed that her head had been pushed about 5 feet into a hole, after which the wheel passed over her head. She was not unconscious at any time; she was extremely irritable and had numerous abrasions about her head. No tire tread marks were seen, but the evidence was indisputable that her head had been run over by the automobile. No fracture was seen on roentgenograms of the skull. The neurologic examination was normal. She made a rapid and complete recovery without sequelae.

Case 2

A 2 year old boy was playing in the back yard of his home when the left front wheel of a 1956 Plymouth station wagon (fig.1), driven by a relative, backed over his head. The car was moving slowly on a sand driveway. The child did not lose consciousness. When admitted to the hospital he was extremely irritable, semicomatose, and mildly cyanotic. Examination of the patient showed tread marks over the left side of the scalp and the left forearm and shoulder. These marks conformed to the spaces between the elevations on the tire treads. Roentgenograms revealed a fracture of both the left temporoparietal and right temporal bones.

Bilateral exploratory burr holes made shortly after the injury revealed thin areas of subdural hemorrhage over both cerebral hemispheres,

From the Section on Neurosurgery, and the Department of Surgery, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C.

Prepared under a grant of the United Medical Research Foundation of North Carolina.



Fig. 1. Photograph of a 2 year old child showing tire imprints on skin. Photograph on right shows tire which made the imprints.

with some yellow fluid. Since there was increased intracranial pressure, a subtemporal decompression was done. The child made a satisfactory recovery. He had an internal strabismus of the left eye before the accident, and his mother said his right eye turned out after the accident. This deformity was subsequently corrected by operation. The child's development has been normal and when last seen two years after the accident, he was normal.

Case 3

A 15 year old boy was injured at the age of 2 when a 1910 Plymouth ran directly over his head. The driver of the car was aware that he had run over something. When he looked back, he saw the child walking away. The child had an extensive scalp laceration on the right side, and the muscles were torn. Although he had some difficulty with his binocular vision for several weeks after the injury, this has cleared and his subsequent development has been normal. Examination on March 27, 1958, when he was first seen here some 13 years after the accident, showed no abnormality except a protuberance in the region of the origin of the right temporal muscle. This was thought to be due to tearing of this muscle, with calcification in the area. Roentgenograms showed no other abnormality.

Case 4

A 2½ year old girl was sitting alone in the driver's seat of a 1951 Nash Ambassador four-door car when it began to move slowly downhill. She rolled off the front seat and fell out of the door. The automobile ran over her head, back, and buttocks, leaving tread marks in these places (fig. 2). She was lethargic but not unconscious and was bleeding from the nose and right ear.



In addition to the tread marks, there were abrasions over the left side of the forehead and the left cheek. Roentgenograms showed a linear fracture in the right temporoparietal region and some diastasis of the sagittal suture.

The patient's condition became stabilized in the hospital; she made a quick recovery, and was discharged after three days. The tread marks faded rapidly. She had done well at the time of discharge, but since she has moved to another city, it has been impossible to follow her since.

Case 5

A 3½ year old boy was playing near the family car, a 1958 Plymouth, when it began to roll backward. The car apparently ran over the child's head on a concrete driveway. He was found lying on the street crying.

Examination showed numerous abrasions, tire

tread marks on the right side of the scalp (fig. 3), and a huge scalp laceration in the left temporoparietal region. It was felt that the laceration was the result of a tearing action against the pavement. The tread marks faded within three days after his injury, his wound healed satisfactorily, and he made an excellent recovery. When last seen eight months after the accident, he was normal.

Case 6

A 22 month old child was sitting behind a parked car on June 3, 1950. The car was seen



to back over him, the back wheel pausing momentarily as it passed over the lower part of the chest and right upper quadrant of the abdomen. The child was pressed against the asphalt road surface on which he was lying for about five seconds before the car was rolled back off him. He immediately became cyanotic, had labored respirations, and petechiae developed over his face and neck. He did not lose consciousness. On the way to the hospital he had a bowel movement and cried.

On admission he was restless, with a blood pressure of 70/30 and a pulse rate of 100 to 110. The next day his blood pressure gradually rose to 110/60, but his pulse reached a level of about 150 to 156, fell to as low as 110, and stayed between 100 and 130 for another four days. It then sharply dropped to normal.

An electrocardiogram showed a P-R interval of 0.12 and a QRS interval of 0.07. Roentgenogram of the chest revealed scattered infiltration of the left lower and mid-lung fields. The urine was clear microscopically. The hemoglobin on admission was 11.2 Gm., the red blood cell count 4,100,000, and the white blood cell count 17,400. In three days the hemoglobin dropped to 7.1 Gm. and the red cell count to 2,950,000. The hemoglobin came back to 8.3 Gm., with 3,380,000 red blood cells and 12,950 white blood cells.

He was observed in the hospital for seven days and made a satisfactory recovery. At the time of discharge roentgenograms of his chest and abdomen were negative. He made a complete recovery, and was not seen again until at the age of 8 years on February 23, 1957, he was examined for an acute respiratory infection, but he was normal otherwise.

Case 7

A 41 year old man was in an automobile

Fig. 2. Photographs of a 2½ year old girl showing abrasions of face and tire tread marks on back.





Fig. 3. Right side of face of a 3½ year old boy. Note tread marks on face and scalp.

accident on February 29, 1952. He was thrown from the car, which turned over on him, and he remained with only his head and shoulders protruding for 1½ to 2 minutes. The car was then lifted from his chest and abdomen. During this time he was noted to turn blue, stop breathing, and he was unconscious. He quickly regained consciousness, started breathing without difficulty, and complained of pain in his chest. He spat up a slight amount of blood.

On admission his temperature was 100 F., pulse rate 78, respiratory rate 20, and blood pressure 100/70. There were obvious petechiae over the head, neck, upper part of the chest, and arms (fig. 4). There were areas of pallor of the skin where compression had taken place.

A second roentgenogram of the chest made on March 4, 1952, showed better aeration of the lungs than on the roentgenogram taken on admission, and no lesion of the chest was recognized. He improved gradually, and was discharged on March 8, 1952. By March 18, 1952, the skin was clear, but the scleras still showed some ecchymosis, with absorption of the blood taking place. The patient continued to have mild complaints as late as eight months after injury, but all objective examinations were negative.

Case 8

An 8 year old boy was playing on an asphalt driveway by his home early in the morning when a car backed slowly over his head and neck. He was brought immediately to the emergency room of the hospital, where tire tread marks were recognized on the left posterior side of the scalp, coursing over the mastoid region. He had no other abnormality except for a fracture of one rib and an abrasion in the region of the right zygoma. The roentgenogram suggested that there might be a linear fracture through the middle third of the right zygoma, but no displacement was seen. There was no fracture of the skull.

The patient made a satisfactory recovery, and was left with no residual abnormality.

Case 9

On June 6, 1956, an 8 year old girl allegedly was run over by the wheel of a truck, moving slowly to park by the side of the street. She was never unconscious.

On admission to the hospital her pulse rate was 124 and her blood pressure 98/60. She was conscious and communicative. There were mottled purple petechiae over the neck and face, and

lacerations in the right groin and right side of the abdomen (fig. 5). There was conjunctival ecchymosis, but no neurologic abnormality. Roentgenograms of the skull, cervical spine, chest, abdomen, pelvis, and the extremities showed fractures of the pelvis and right femur.

There was slight blood-streaked vomitus for three days. Six days later the ecchymosis of the face was clearing. She remained in the hospital for three weeks, made a good recovery and was discharged to return as an outpatient for further treatment of the fractures of her pelvis and femur. No neurologic or thoracic abnormality persisted.

Case 10

On December 15, 1954, a 6 year old boy on the way to school was allegedly struck by an automobile. The car stopped as quickly as possible, but it was necessary to back it up in order to extricate the child. He was rendered unconscious but regained consciousness before the ambulance arrived.

On admission his respiratory rate was 28, pulse rate 108, and blood pressure 95/50. Many petechiae were on the face and neck, and there



Fig. 5. Congestion of face and neck from thoracic and abdominal compression in an 8 year old girl.

was conjunctival ecchymosis. There was an abrasion of the right knee and extreme tenderness in the right costovertebral angle and the abdomen. He was observed closely and he improved rapidly. No blood was found in the urine. There were subconjunctival hemorrhages in both eyes, and one small, round hemorrhage in the region of the right macula. No evidence of fracture of the chest or skull was seen. When he was last seen on December 27, 1954, the petechiae had cleared from his face and the subconjunctival hemorrhages were clearing.

Case 11

A 2½ year old child was apparently playing in the driveway of her home in La Puente, California, on July 8, 1958. A photograph of this child was published in an Associated Press wire photograph (fig. 6), and information was obtained from her mother in a detailed letter. A quotation from her letter follows:

"The car, a 1950 Hudson 4-door, 6-cylinder, weighing about 3,890 pounds, was parked in the driveway, about a 15 per cent grade, with the brake set and the overdrive on. It backed down the driveway and into the street, upgrade, then rolled forward, downgrade. Both front wheels jumped the curb and came to a stop in the yard; the back wheels were in the street.



Fig. 4. Head and chest of 41 year old man whose chest and abdomen were compressed by weight of overturned automobile. Photograph shows severe congestion of capillaries of face, neck, and arms with pallor of skin in compressed areas.



Fig. 6. A. Tire tread marks on face of 2½ year old girl (photograph courtesy Los Angeles Examiner). B. Photograph of tire showing tread.

"It rolled over Ronna on the way back, as a neighbor saw it as it started forward, and she rolled out of the way in time to keep from getting run over again. No one saw her run over.

"We thought it was the left rear wheel that ran over her, but when we checked it, we saw that this tire was too smooth, so it must have been the left front wheel. The tire had about 35 pounds of air and is about one-third worn . . . The marks on her face were like red tattoo marks and were completely gone in a week. The skin was not broken any place. She had a small abrasion behind her right ear and another on her back. These were the only injuries she sustained."

Discussion

The multiplicity of ways in which human beings may be injured as the result of rapid modern transportation is all too familiar. The loss of life from automobile accidents, amounting to more than 38,000 people in the United States during 1959, has led to numerous interesting statistical analyses and studies of individual type of injuries.

Certain designs and types of vehicles may lead to a particular type of accident as illustrated some years ago in a study by Kitahata, Alexander, and Davis² of a series of children who had been

injured by falling from the rear door of moving automobiles. They found that the injuries occurred as the result of the door being hinged on the back post of the car and being pulled open by the rush of the wind as the latch was opened, throwing the small child with his hand on the handle out of the car. The simple expedient of hinging the back door of automobiles to the center post has almost completely obviated this particular accident.

If the abdomen or the thoracic cavity of a person, particularly a child, is run over by a slowly moving automobile, tire tread marks are likely to be left on the skin and to be clearly recognizable for three or four days after the accident, provided there is enough tread on the tires. The secondary effects of compression of the abdomen or thorax, however, are well known and have been described for many years as "traumatic asphyxia," "ecchymotic mask," "diffuse ecchymotic infiltration of the face," or "ecchymotic pressure stasis."

Review of literature

The first recorded description of such a patient was by Ollivier (d'Angers), who in 1837 described 23 persons who were crushed to death in a crowd at Champs de Mars.³ Autopsies disclosed that, although the victims had multiple hemorrhages in the head and neck, the brain

was free of gross hemorrhage except in one case in which some bloody exudate was noted over the cerebral hemispheres.

Later, in 1855, Hardieu⁴ reported 30 persons injured by being crushed in a panic at Placade la Concorde — 9 fatally. He also was impressed by the integrity of the brain in the two persons on whom he performed autopsies. He believed that the ecchymotic appearance of the face and the neck was the result of multiple petechial hemorrhages.

The first clear-cut picture of this symptom-complex was made by Perthes in 1898⁵. In 1904 Beach and Cobb⁶ described the dramatic case of a man whose chest was caught between a wall and a moving elevator and who had to remain in this position for some time before he could be moved. There was pronounced ecchymosis of the head and neck and a sharp line of demarcation at the clavicles between normal and ecchymotic skin. The discoloration cleared within three to five days, but there were still some hemorrhages in the conjunctivas. There were no retinal hemorrhages. Microscopic studies of tissue excised from the face showed no blood outside the walls of blood vessels.

In 1905 Milner⁷, in discussing 6 cases, conjectured that the mechanism of this type of injury was thoracic and abdominal compression occurring on reflex inspiration with closure of the glottis. It was his impression that the lack of competent valves in the jugular vein contributed to the congestion of the face and the neck, but this theory did not explain why the brain was spared.

In 1908 Bolt⁸ described a man who had been caught between two "vestibule cars." He wore a tight inspector's hat, and while he was being extricated it was noted that his face and neck assumed a violet-blue color, with bulging of his eyes. He was in the state of compression for three to five minutes, and his entire face and neck were extremely ecchymotic except for normal-appearing skin in the region where the headband had been pulled down over his forehead.

Numerous cases have been recorded subsequently—by Despard in 1909⁹, Sikemeier¹⁰, ten Horn¹¹, and Aievoli¹². A great many cases were reported and adequately summarized by these authors: some followed severe epileptic seizures or prolonged episodes of coughing, and one occurred in a child who had a large umbilical hernia operated on under general anesthesia.

The most interesting points to be made in run-over accidents are first that tread marks may be left on the body or thorax if there is enough tread on the tires, and second that severe congestion may occur in the head and neck, sparing almost completely the rest of the body including the arms, though the line of demarcation varies. The brain seems to be spared, except in a few fatal cases of extremely severe compression. The most common outcome is a

rapid disappearance of the ecchymosis within three to five days; however, conjunctival hemorrhages usually remain for several days and there are usually no retinal hemorrhages. When the skin is studied microscopically, no petechial hemorrhages are found; the blood is heavily congested in the small blood vessels, but not outside the vascular walls.

Medicolegal aspects

Since 1920 interest in "traumatic asphyxia" or "ecchymotic face mask" has seemed to lag, but as automobiles have become heavier and the tread on tires deeper, a number of papers, particularly of a medicolegal nature, have appeared. Initially these were most common in the German literature.

A textbook on legal medicine published in Berlin in 1927 by Hofmann and Haberda¹³ contained two illustrations of patients allegedly bearing tire tread marks. This was the interpretation made by Ortmann¹⁴ in 1932, although a study of the pictures would suggest that the imprint on their faces was made by the radiators of the automobiles rather than by the tire treads.

Ortmann¹⁴ did, however, describe three children with tire tread marks on the head who died immediately or soon after accidents. His chief contention was that the offending vehicle may be traced by a study of the tread marks. Ortmann felt that a severe blow of the tire was necessary to produce typical tread marks in the skin; however, Borchard¹⁵ presented two people run over by vehicles in whom the mere pressure of the tire was sufficient to produce changes in the skin. A very complex study of physical forces was made concerning the manner in which one might determine whether the offending wheel had been in acceleration, deceleration, what the velocity might have been, what the weight of the car was, and numerous other points which may be of medicolegal significance.

In 1941 Fritz¹⁶ reported a most interesting patient. A man pushed his cart in front of the last vehicle in a convoy of the Nazi Secret Police, the **Schutz Staffel**. A front wheel of this vehicle passed directly over the head of the victim. He was killed by the accident, and examination showed fracture of the skull and contusion and crushing of the chest. There were characteristic tread marks on the left cheek and temporal and frontal regions, but instead of corresponding to the raised pattern of the actual tire, the marks conformed to the interspaces between the protruding parts. This was attributed to pressure of the protruding parts on the skin, pushing the blood out of the affected vessels into the capillary beds of the narrow, pressure-free areas corresponding to the gaps between the treads. The excessive in-flow of blood from all sides into the pressure-free areas leads to enormous

over-filling and distention of the capillaries, which break and create the local hemorrhages. Microscopic examination of the skin showing tread marks revealed small extravasations of blood in the epidermis in addition to ruptured blood vessels. No trauma to the upper epidermal layers could be found, but it was thought that the hemorrhages directly under the epithelium were readily visible through the epidermis.

In 1943 Kassai¹⁷ reviewed this particular problem again from the medicolegal point of view and presented a complex analysis of the whole subject.

Summary

1. A review of the English, German, French, Dutch, and Italian literature has been made of run-over or uberfahren accidents.

2. Eleven cases are presented with illustrations.

3. The head, even that of a small child, may be run over by a slowly moving wheel of a modern automobile, leaving tire tread marks but exerting relatively mild damage of a permanent nature in some instances.

4. When the thorax or abdomen is similarly compressed, a most interesting syndrome of congestion of the small vessels of the head and neck may result. The brain in such cases is usually spared.

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Knowledge of the metabolism of iron is so advanced that it is possible to determine who will benefit from treatment with iron and who will not and to prescribe iron in the cheapest and most efficient manner. Nevertheless, the *Physicians' Desk Reference*, prepared with the cooperation of the "ethical" drug companies, lists such a wide variety of iron preparations, with so many added substances of no conceivable use, that it is obvious that the information now available on iron metabolism has not reached the majority of the medical profession. Yet, a knowledge of the basic aspects of iron metabolism is absolutely essential for the rational use of iron.—Block, M.: The Clinical Pharmacology of Trace Metals and Iron, *Clin. Pharmacol. & Therap.* 1: 751 (Nov.-Dec.) 1960.

Pulmonary Involvement by Hodgkin's Disease

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It has long been recognized that Hodgkin's disease is primarily a lymphogranulomatous disease and that classic Hodgkin's disease involves the cervical chain of lymph nodes most often. This impression is borne out in a study of Peters and Middlemiss¹ in which it was found that the initial site of involvement by the disease in 151 of 291 cases was the cervical chain of lymph nodes. What may not be equally as well recognized is that the incidence of pulmonary parenchymal involvement, although rarely an initial manifestation of the disease, is rather high in the terminal stages. In 5,200 routine autopsies reviewed by Rottino and Hoffman² there were 83 cases of Hodgkin's disease, 40 of which showed pulmonary involvement. Falconer and Leonard³ reported pulmonary involvement in 37.6 per cent of 125 cases of Hodgkin's disease reviewed. Verse⁵ found an incidence of 50 per cent, only 10 per cent of which he felt to have arisen primarily in the lung parenchyma and extended secondarily to the bronchopulmonary and mediastinal nodes. Seven authors cited by Falconer and Leonard³ reported an average incidence of pulmonary lesions of 40 per cent.

The gross pathologic appearance of the lesions is variable. The lesion may occur as one of the following types: discrete nodules; diffuse pneumonic involvement; lobular, confluent lobular, and bronchopneumonic involvement; bronchitic involvement; and miliary lesions. The discrete nodular involvement is commonest and the miliary type rarest². It can readily be seen from the variable appearance of the lesions that Hodgkin's disease of the pulmonary parenchyma can be confused with lobar pneumonia, bronchopneumonia, disseminated tuberculosis, sarcoidosis, carcinoma, or many other pulmonary diseases.

Histologically, the initial reaction in the lung parenchyma is one of bronchiolitis and alveolitis. Fibrin, leukocytes, plasma cells,

and large mononuclear phagocytes fill the alveoli. This exudate then organizes by the formation of specific granulomatous and non-specific fibrous tissue. Thickening of the alveolar wall occurs. The intrapulmonary nodules of lymphoid tissue are converted into granulomatous masses showing the histopathologic characteristics of Hodgkin's disease and later dense fibrous tissue⁴. It has been suggested that the resistance to x-ray therapy of pulmonary lesions in this disease may be due to the fact that the lesions are characteristically predominantly fibrous or sarcomatous².

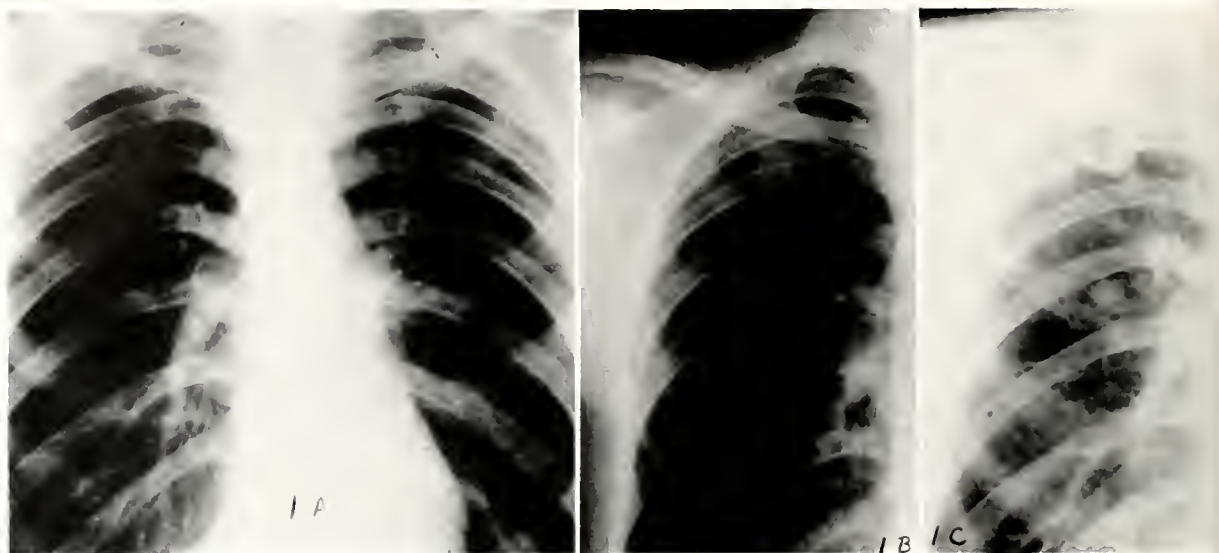
Case Reports

In order to review the clinical course and x-ray findings in patients with pulmonary Hodgkin's disease, three case histories of patients with this manifestation are presented.

Case 1

The patient was a 24 year old white married male assistant golf professional who was seen on July 26, 1956, because of constipation, fever, and weight loss for the year prior to his initial visit. For the first six months of 1956 he had experienced recurrent episodes of chills and fever as high as 103 F., with remissions after five to six days and recurrences at three and four week intervals. During the three months before the initial visit he had become increasingly aware of a tender, visible, firm mass in the left lower quadrant of the abdomen.

On physical examination the weight was found to be 147 pounds, temperature 101 F., pulse rate 84, and blood pressure 110 systolic, 55 diastolic. The patient was well developed but thin and pale, showing evidence of recent weight loss. Examination of the abdomen revealed a palpable, firm, tender, fixed mass, measuring 3 x 5 inches, lying just to the left of the mid-line at the level of the umbilicus. In addition, there was a visible and palpable, firm, tender, fixed mass measuring 1 x 1 inch just superior to the left inguinal ligament. There was generalized tenderness in the left lower quadrant of the abdomen, but the liver, spleen and kidneys were not palpable. Except for bilateral axillary lymphadenopathy, the remainder of the physical examination was



Case 1

Fig. 1. Film 1A showed the chest to be normal in 1956. On October 29, 1958, films of the chest showed a 2 cm. area of infiltration in the right first anterior interspace (1B). At this time the

possibility of tuberculosis was strongly considered. On February 16, 1959, the area of infiltration became larger and a cavity was clearly demonstrated on film 1C.

not significant. A hemogram and urinalysis revealed only hypochromic anemia.

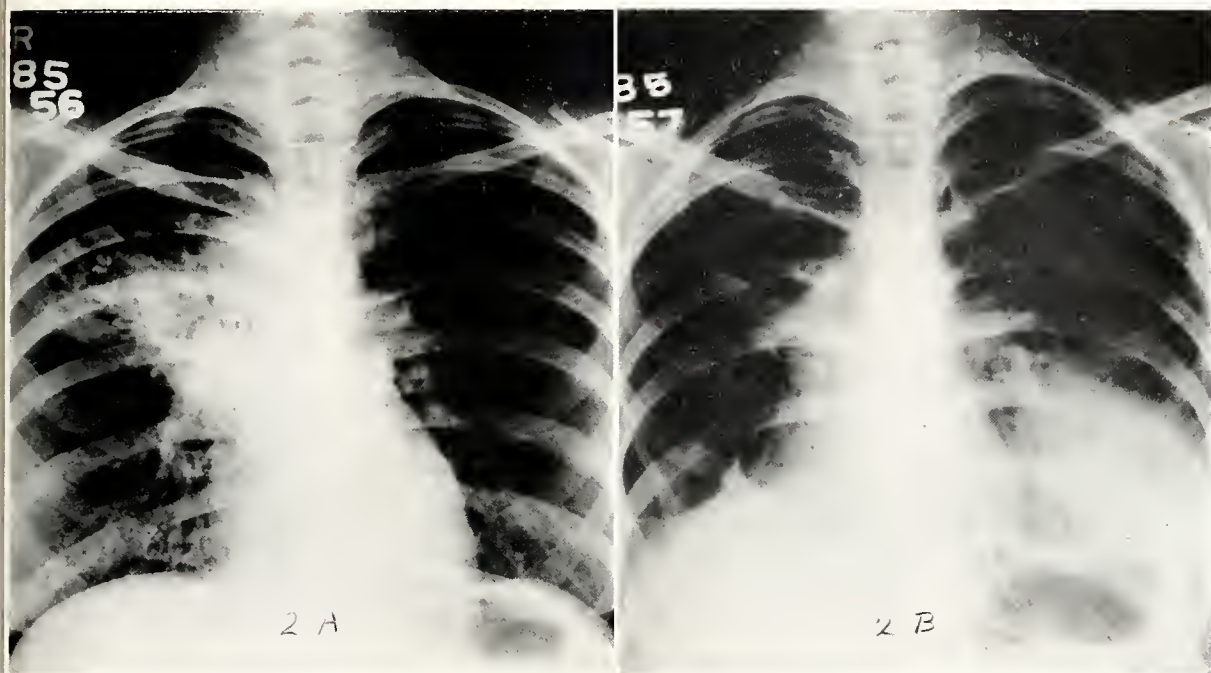
The clinical diagnosis was abdominal Hodgkin's disease, and the patient was hospitalized at Moses H. Cone Hospital for evaluation. A chest roentgenogram, barium study of the colon, and excretory urograms were negative. On July 31, 1956, surgical biopsy of the left inguinal mass was carried out, and the pathologic report confirmed the clinical diagnosis of Hodgkin's disease. On August 1 x-ray irradiation over the left abdomen was initiated and was tolerated well. The patient became afebrile and was discharged on August 4, 1956, to continue x-ray therapy and oral hemantins.

From that point he was observed closely at frequent intervals.

The course was one of recurrent variable exacerbations of fever and pain in the cervical, thoracic and lumbosacral parts of the spine, in the left upper quadrant of the abdomen, and in the left thoracic pleural region. Each of these episodes was evaluated individually as they occurred over a period of 11 months and palliative x-ray irradiation was given as indicated, with benefit on each occasion. Supportive and symptomatic therapy was maintained, and hematologic studies at regular intervals showed adequate levels of hemoglobin, erythrocytes, and leukocytes. The weight was maintained at an average of 145 pounds. In October, 1957, he was given a course of triethylene melamine orally. On March 24, 1958, he continued to complain of left thoracic pain in spite of what was considered

adequate x-ray therapy, and oral Prednisone, 5 mg. four times daily, was instituted. He continued to have exacerbations of pain in various sites, however, and x-ray therapy at intervals was continued, along with the Prednisone in a dosage of 20 mg. daily. In September, 1958, a course of chlorambucil, 10 mg. daily, was instituted in addition to the Prednisone and other supportive therapy. Chlorambucil was continued for five weeks, during which he showed deterioration, with slight weight loss, increased fatigue, and marked anorexia.

On October 29, 1958, a chest roentgenogram revealed a vaguely defined 2 cm. circular area of infiltrative density in the right infraclavicular region. In view of the prolonged steroid therapy and the appearance of the lesion, pulmonary tuberculosis had to be considered, but pulmonary Hodgkin's disease could not be ruled out. Steroid therapy was discontinued. The right apical infiltration persisted and increased in density over the next two months by serial chest x-rays. Concomitantly the patient began to feel much worse, experiencing marked weakness, fatigue, and increasing cough. Sputum examinations for tubercle bacilli were repeatedly negative. The weight dropped from a previously stable level of 145 pounds to 138 pounds. The hemoglobin dropped from 9.2 Gm. on January 1, 1959, to 7.6 Gm. on February 16, 1959. On this date a follow-up chest roentgenogram revealed cavitation of the previously described density in the right upper lung field, and the patient was again hospitalized for study.



Case 2

Fig. 2. A film of the chest on May 1, 1956, showed a large 7 cm. mass in the right upper medial lung field. Retained oil from a previous bronchogram was also noted. The lesion was removed following this examination and the pathologic diagnosis was pulmonary Hodgkin's disease.

Extensive study of the cavitary lesion by sputum examination, gastric washing, and guinea pig inoculation failed to reveal any tubercle bacilli, and it was concluded that this pulmonary lesion must be considered a manifestation of Hodgkin's disease. Laminograms confirmed this impression, and the patient was discharged on March 17, 1959. Jaundice had developed during a course of intravenous nitrogen mustard therapy, and this rapidly deepened. Marked edema appeared, associated with a total serum protein level of 4 Gm. and albumin of 2.6 Gm. The hemoglobin dropped to 3.9 Gm. in spite of blood transfusions. He became rapidly weaker and more comatose, and died on April 14, 1959.

Autopsy revealed the body of an emaciated, jaundiced white male with scattered petechial lesions over the skin. There were dense fibrous adhesions binding the apex of the right lung and the posterior surface of the left lung to the thoracic wall. There was about one liter of bilateral pleural effusion. Dull, gray, rubbery nodules were scattered throughout the lung parenchyma. In the right apex was found a 2 cm. spherical cavity with irregular lining and a wall measuring 1 cm. in thickness. The lining of the cavity was covered with a gelatinous

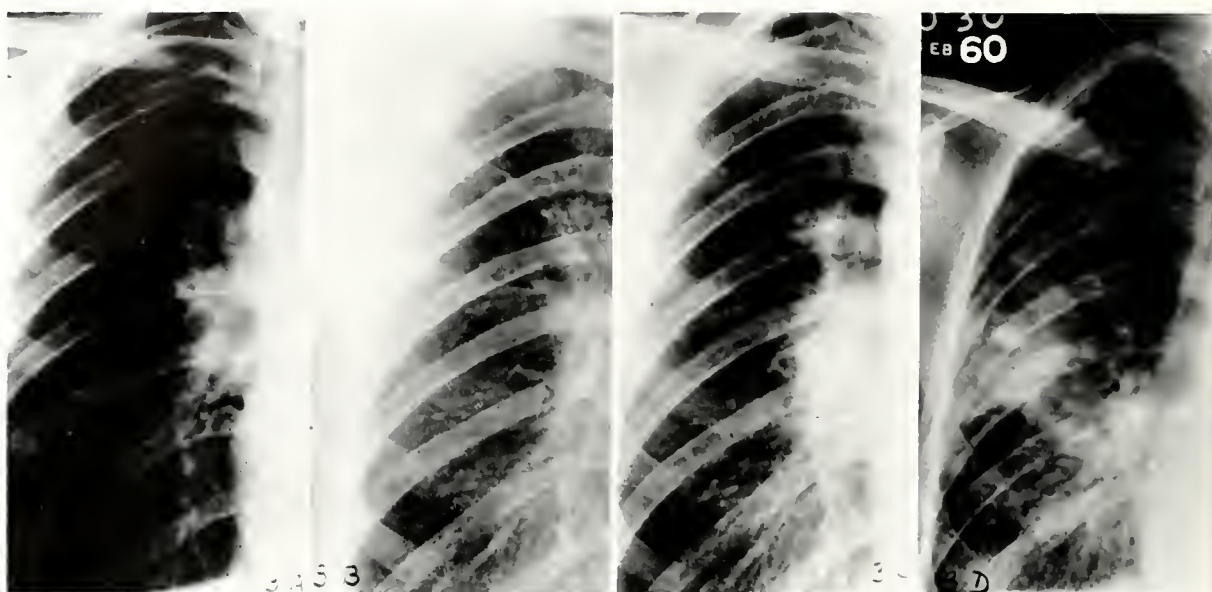
Films taken three and six months postoperatively were normal. Nine months following operation a large area of infiltration was demonstrated in the left lower lobe (2B). This proved to be pulmonary Hodgkin's disease at autopsy.

yellow exudate. Concentrated smears and cultures for tubercle bacilli and fungi were taken from the cavity, but showed no evidence of acid-fast organisms or fungi.

In addition, Hodgkin's disease had involved the epicardial fat, spleen, bone marrow, lymph nodes, liver, pancreas, kidneys, and adrenals.

Fibrosis dominated the histopathologic picture, with scattered areas of cellular structure in which typical Reed-Sternberg cells could be identified.

Case 1 presents an example of pulmonary parenchymal infiltration by Hodgkin's disease of the discrete nodular type, which progressed to necrosis and cavitation. This complication presented a difficult and troublesome diagnostic problem, primarily because the lesion in the right apex behaved clinically and radiographically like a tuberculous lesion. The difficulty in differentiation was compounded by the fact that adrenal corticosteroids, with a known ability to light up a tuberculous lesion, had been administered regularly over an eight-



Case 3

Fig. 3. Film 3A taken six months following the initial diagnosis of Hodgkin's disease showed right hilar and right paratracheal adenopathy. There was also a suggestion of minimal pulmonary infiltration in the right upper medial lung field.

Film 3B showed regression of the adenopathy following irradiation, but the pulmonary infiltra-

tion just above the right hilus became more evident. Three months later the right hilar adenopathy returned and the 2 cm. area of pulmonary infiltration became more dense (3C).

The patient continued on a downhill course with roentgen evidence of extensive pulmonary involvement in February, 1960 (film 3D).

month period. Finally, it is apparent that rapid, unalterable deterioration began concomitantly with the appearance of the right apical pulmonary lesion, in spite of what was considered adequate therapy.

Case 2

A 20 year old white housewife complained of slight weight loss and cough of three months' duration. Physical examination and routine laboratory work was normal. A chest roentgenogram showed a mass in the right upper lung field. A bronchogram done elsewhere was not helpful in the diagnosis. A right upper lobectomy was done in May, 1956, with a pathologic diagnosis of pulmonary Hodgkin's disease. Postoperative x-ray treatment was given to the operative area. There was no evidence of any other involvement at this time.

Films of the chest taken three and six months postoperatively were normal. Nine months following operation pulmonary infiltration developed in the left lower lobe. A tumor dose of 2,200 roentgens was administered over a three-week period using 220 kilovolt x-ray therapy. The infiltration regressed very little and the patient began a progressive downhill course.

Nitrogen mustard and additional x-ray therapy were given without benefit, and the patient expired. An autopsy showed extensive involvement of both lungs.

The liver, spleen, and internal lymph nodes were extensively involved with Hodgkin's disease.

Case 3

A 29 year old male was admitted to the hospital because of an enlarged right cervical lymph node, fever, and malaise. Biopsy of this node established the diagnosis of Hodgkin's disease. A chest roentgenogram showed right hilar lymphadenopathy. In March, 1958, he was started on chlorambucil, 12 mg. daily, for one month, and then 10 mg. daily for two additional months. At the end of this three-month period his white blood cell count was 3,600, with 123,000 platelets. During this interval all symptoms abated. Since the hilar enlargement persisted, x-ray therapy was given to the mediastinum and neck. In October, 1959, because of recurrent chills, fever, and night sweats, chlorambucil was resumed in a dosage of 4 mg. daily, which was gradually increased to 12 mg. daily for a period of six weeks. Additional x-ray therapy was given to the mediastinum and right upper lung without

significant benefit. The patient's condition gradually became worse, and he expired in February, 1960, with extensive pulmonary involvement.

This patient showed the typical lymphadenopathy associated with Hodgkin's disease. In addition, there was an area of infiltration in the right upper medial lung field which was treated along with the hilar lymph nodes. There was some improvement following x-ray therapy, but the pulmonary lesion persisted in spite of intensive treatment. It was our feeling that the pulmonary lesion was less responsive to x-ray than the lymph nodes.

Summary

1. Three cases of pulmonary involvement by Hodgkin's disease are presented.

2. Pulmonary parenchymal involvement is rare in the early clinical stage of the disease, but the incidence at autopsy has been found to be about 40 per cent³.

3. The roentgen and gross pathologic appearance of the lesion ranges from

discrete nodular lesions to a miliary distribution.

4. The pulmonary lesions frequently present a difficult diagnostic problem in that they may simulate a variety of pulmonary diseases.

5. The prognosis in cases with pulmonary involvement is considered very poor, and response to all forms of treatment is disappointing.

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Control of the Body Temperature in the Pediatric Patient

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The regulation of body temperature is normally so efficient that we give it little thought save for selecting the type of clothing we or our children wear according to the outside temperature. With the advent of more heroic surgical techniques, the use of "hypothermia" has become more widespread as a measure to preserve the function of vital structures. This has led to a somewhat fuller realization of the effects of temperature in man, but there is unfortunately still no real appreciation of the problems associated with deviations from normal temperature. As with nearly everything else, these problems become accentuated in the pediatric patient. Two cases rather dramatically illustrate this point.

Case 1

The patient was a 9 year old boy who was undergoing a revision of an endaural tympanoplasty. No difficulty had been encountered with the first procedure 15 months previously. There was no history of serious illness or disease.

He was given 6 mg. of morphine sulfate and 0.2 mg. of scopolamine hydrobromide 90 minutes before induction of anesthesia, which was accomplished without incident by 125 mg. of thiopental sodium given intravenously. Oral intubation was accomplished with ease following the intravenous injection of 20 mg. of succinylcholine. A solution of 5 per cent dextrose in water was administered throughout the procedure at a rate of 75 cc. per hour. Anesthesia was maintained on a mixture of 0.8-1.0 per cent halothane, 50 per cent nitrous oxide, and 50 per cent oxygen in a circle filter, semi-closed system. Blood pressure, pulse, and respiration remained stable for about two hours, when the respiratory rate began to increase, the blood pressure began to drop gradually, and the heart rate became more rapid

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and occasionally irregular. The halothane was discontinued, but the anesthesia became so light that the patient began to move, whereupon ether was introduced into the mixture. Vital signs continued to deteriorate, and after about three hours and fifteen minutes the pulse and blood pressure were suddenly unobtainable and respiration ceased. Controlled respiration was immediately begun, but some delay in opening the chest resulted in a lapse of three minutes before effective cardiac massage was instituted. The heart responded quickly to defibrillation. The rectal temperature at this time was 103.4 F. (39.7 C.). The patient was placed in hypothermia at 35 C., but he never regained consciousness. He died six days later.

At autopsy the only evidence for cause of death was that associated with the period of hypoxia and the hypostatic pneumonia.

Case 2

A 3 month old girl weighing 1.3 kilograms was brought to the operating room for artificial creation of suture lines. With the exception of the distorted head, there was no history of disease or abnormality. Anesthesia was induced with vinethene and ether by open drop. The patient was intubated under direct vision, and anesthesia was maintained with ether, nitrous oxide, and oxygen. She was placed in the prone position. The room temperature was 71 F. The body temperature at the beginning of surgery was 37.5 C. and at the end of the operation, two hours and 40 minutes later, it had dropped to 32.9 C. Paralleling the drop in temperature, the pulse fell from an initial value of 210 to a final value of 160. Respiration slowed from 48 per minute to 40 per minute, and throughout the operation respiration was assisted. In this case, although the temperature fell almost 5 C., there was no evidence of interference with normal physiologic processes.

These cases point up the fact that under surgical conditions the exquisite temperature-regulating mechanism with which the body is provided failed to function. Many additional illustrations of the deleterious consequences of severe changes in body temperature could be presented, and several articles have dealt exclusively with this problem in children.

Body temperature is regulated reflexly, so that the amount of heat lost is equal to the amount of heat produced. The so-called thermoregulatory center lies in the hypothalamus. The actual sensing receptors are not so well identified, but apparently the temperature of the blood going to the hypothalamus and the thermoreceptors in the

skin, muscle, and other organs influence the center. It is also subject to a limited degree of control by higher centers.

The body can lose heat by four methods: (1) *conduction*—that is, by transfer of heat directly to a substance in contact with the body; (2) *convection*, or the heating of air which rises and is replaced by cooler air which is in turn warmed; (3) *radiation* to other substances with lower temperatures; (4) *evaporation* of body fluids. Normally all methods function to dissipate the heat produced by metabolic processes. Radiation and evaporation are the most effective means, but all can be of importance in reducing body temperature.

Under circumstances such that heat loss, from whatever means, becomes excessive, the body tends to conserve heat as much as possible. The blood flow through the skin is reduced by vasoconstriction and sweating stops. If this does not maintain temperature, then steps are taken to increase heat production. This is done chiefly by muscular contraction, which may be minimal—a tensing of the muscles and pilo-erection—or more vigorous, when we term it shivering.

Effects of Changes in Body Temperature

Alterations in body temperature affect the functions of the body. These are outlined in tables 1 and 2. In general, elevation of body temperature increases metabolism. At extreme elevations (above 41 C.) the respiratory and circulatory systems can no longer cope with the demand of the tissues, and hypoxia develops, which uncorrected will lead to death. On the other hand, a decrease in body temperature generally reduces metabolism. At extreme reduction in temperature the metabolism of the circulatory and respiratory organs is so impaired that they no longer function, and death again will result. At temperatures below 30 C. apnea and cardiac arrest may occur.

The child brought to the operating room is no longer physiologically normal. He has fasted and his metabolism is basal. There is a certain amount of central nervous system depression, which reduces muscular activity. His heat production therefore is minimal. An anticholinergic drug has been

Table 1

Effects of Hyperthermia

O₂ consumption increases 7% per degree F.
 Respiratory rate increases 5% per degree F.
 Heart rate increases 5-10 beats per degree F.
 Sweating increases, with fluid and electrolyte loss
 Blood volume decreases
 Vascular capacity increases
 Blood pressure falls
 EEG becomes abnormal
 Anesthetic requirements increased

Table 2

Effects of Hypothermia

O₂ consumption decreases 6% per degree C.
 (Shivering increases O₂ consumption)
 Respiratory rate decreases
 Heart rate decreases
 Vasoconstriction is marked
 Vascular capacity decreases
 Blood pressure falls
 Coronary flow increases
 Anesthetic requirements reduced

given and sweating is abolished, or at least seriously impaired. Upon this is superimposed further depression of the central nervous system by the anesthetic agent. Except in the very lightest levels of anesthesia, this inactivates the thermoregulatory center and the child is now poikilothermic or "cold-blooded." His body temperature will depend upon his environment.

Waltman and Scott showed that within 30 minutes after the start of anesthesia the skin temperature of the thigh and great toe approached the rectal temperature, even in cool operating rooms. With the relatively large ratio of surface area to body weight seen in small children, the small amount of heat produced in the basal metabolic state of anesthesia is lost by radiation and conduction through this very effective radiator when the environmental temperature is low. Conversely, if the environmental temperature is high, this "radiator" can then absorb heat much more quickly.

Additional insults are heaped upon this defenseless body, however. The patient's respiration is altered so that he may be breathing a cold, almost dry gas, as in open-drop ether anesthesia. The heat required to vaporize the ether comes from the inspired air, which readily reaches 0 C., or less. At this temperature it is nearly dry, but upon expiration it is 95 per cent saturated with water vapor at body temperature. The heat required for vaporization must come from the patient, and in children up to 25 per cent of the body's heat production may be lost in this way. With the non-rebreathing technique, although the gas is at room temperature, it is absolutely dry, and as much heat is lost in saturating the gas with water

vapor as is lost in the open drop technique.

If soda lime is used, then heat is liberated in the reaction between carbon dioxide and the soda lime. When the to-and-fro system is used, the inspired gas becomes hot and saturated with water vapor so that it now gives heat to the cooler lungs. When the soda lime is some distance from the mask, as in the circle system, the temperature of the inspired gases is that of the room, although they remain saturated with water and no cooling effect is obtained by evaporation.

Operating rooms seem to be either too hot or too cold. When they are cold the linen is cold, the instruments are cold, the air is cold. The child then tends to lose heat by radiation, conduction, and, if lightly draped, by convection. If in addition, there is an extensive incision, large moist surfaces are exposed where evaporation takes place, even though the child is not sweating, and this is the most effective means of lowering body temperature.

When the room is too hot, or when the humidity is so high that evaporation is inhibited, the heat-loss mechanisms are at best inhibited, or at worst heat may actually be absorbed from the lights, hot lap. pads, and so forth.

It is not surprising, therefore, that the temperatures reported in the literature are so varied. Bigler and McQuiston, in 1951, reported that 60 of 98 patients developed fever while under anesthesia. On the other hand, Harrison, Bull and Schmidt recently reported marked falls in body temperature during anesthesia. In 607 children anesthetized at Duke Hospital in the past 6 months; 84 per cent had a subnormal temperature at

the end of anesthesia. In each of these series the children under one year of age showed the lowest temperatures. In children above this age the average temperature rise recorded in Bigler and McQuiston's data was 0.9 C. above normal (37.5), whereas the Duke patients are 1.0 C. below normal.

Although it is difficult to compare data of this sort, two striking differences between the series may be noted. The patients at Duke were anesthetized in air-conditioned operating rooms using principally non-rebreathing or open-drop techniques. The patients at Children's Memorial Hospital in Chicago were anesthetized largely using a to-and-fro technique in a nonair-conditioned room. One fact is incontrovertible—the temperature levels reached by children under anesthesia are capricious.

Methods of Controlling Temperature

How, then, can the body temperature be controlled, and in what range? The first requirement is that the anesthesiologist know what the temperature is. This is easily done with a relatively inexpensive electrical resistance thermometer. With the flexible probe inserted into the rectum or esophagus, a continuous record of body temperature may be obtained.

In children below the age of 6 months, and probably in all children in air-conditioned operating rooms, efforts must be made to conserve body heat. Keeping the child covered at all times, preferably with loosely woven cotton sheet blankets, is a simple but effective device. It is just as important in the preanesthetic and postanesthetic period as during surgery.

Once anesthetized, the child becomes poikilothermic. With his metabolism markedly reduced and with his relatively large surface area, he will rapidly lose heat to his environment, and insulation now becomes impractical in many surgical procedures. The increased heat loss may be combated easily by the application of external heat. This may be done with warm bottles or some form of a heated mattress or pad. Care must be taken to see that the temperature of the water bottle or mattress does not exceed 105 F., for severe burns may be

caused at pressure points with higher temperatures.

The most satisfactory device in our experience has been a water mattress placed on the operating table and covered with a single layer of cloth. Water at the desired temperature may be introduced into the mattress when body temperature gets too low. More elaborate mattresses which circulate water at a controlled temperature are available. These have proved to be eminently satisfactory, particularly in procedures carried out under hypothermia, but the cost is greater.

Children do not always get cold under anesthesia. At times it becomes necessary to operate on a febrile child, or the environment is such that the child absorbs heat after he is anesthetized. Again it is essential that the body temperature be known. Heat loss can be facilitated by covering the patient with a minimal amount of drapes and cooling the body surface. The heat exchanger used for warming—water bottles or mattress—can now be used to cool by filling them with ice water. In cooling the patient, care should be taken to prevent shivering, if possible, since this markedly increases the oxygen requirements of the body and abolishes the muscular relaxation required in some surgical procedures.

A moderate reduction of body temperature during surgery seems to be beneficial. Less anesthetic is required and there is less danger of hypoxia or hypercarbia developing, particularly if respirations are assisted. Certainly patients whose temperature throughout surgery is between 36 and 34 C. (96.8 to 93.2 F.) seem to have less morbidity postoperatively than those whose temperatures were above 37.

Once the anesthetic is discontinued, the child's temperature-regulating problem is not solved. Recovery from the central-nervous-system depressant drugs he has received may be slow, and in this period temperature-regulating mechanisms are not operating efficiently. The child who was doing well when his respirations were assisted under anesthesia may suddenly breathe so slowly, if cold, that ventilation is inadequate.

As the cold child emerges from his anesthetic depression he may start to shiver violently. This mechanism warms him quickly, but in the process his oxygen requirements are markedly increased. Very often he produces so much heat by this means that he cannot dissipate it, and his temperature may reach 38.5 or 39 C. (101.3 or 102.2 F.) before returning to normal. This shivering process seems to be reduced if the skin temperature is elevated. Covering the patient with a blanket and placing warm water bottles around the body frequently prevent shivering and the associated overshooting of temperature.

If the recovering child is placed in a hot environment, as so frequently happens when he leaves the air-conditioned operating room, he may not only absorb heat, but, if the anticholinergic drugs are still present in the body, he may not be able to sweat. At environmental temperature levels above 94 F. sweating is the only effective means of dissipating heat. It is just as essential that the metabolism of the recovering patient be kept within normal limits as it is for the anesthetized child, and prompt measures must be taken to reduce the tem-

perature. Sponge baths with ice water and the application of ice bags are effective ways of cooling postoperative patients.

Summary

Many of the problems associated with pediatric anesthesia arise from failure to recognize the deviation from normal body temperature. In the conscious patient, temperature is regulated by hypothalamic control of the complex means of conserving or dissipating body heat. Under the conditions of the operating room the patient becomes poikilothermic and frequently is subjected to an abnormally cool or warm environment which causes a decrease or increase in body temperature. These changes are much more evident in pediatric patients because of their smaller body mass and relatively greater surface area.

Less disturbance of the child's physiologic processes will result if his temperature is constantly monitored and, utilizing our knowledge of temperature regulation, is maintained at a normal or slightly subnormal level. The same vigilance must be exercised in the postanesthetic period.

Problem Women and Women's Problems

ELEANOR B. EASLEY, M. D.

DURHAM

After watching my difficulty with preparing this paper, my husband told our next-door neighbor that I had a narrow intellectual pelvis, and so gave birth to ideas slowly and with great pain. That was indeed the case with this particular labor, and some of the results may not appear to be full-term, at that. They are, however, as one of my friends said about her first-born, "the best I could do with the help I had." When I got my medical school and hospital training (and I am afraid it is still so), tuition and direction in the area I am about to discuss were hard to come by.

The Frequency of Psychosomatic Problems in Gynecologic Practice

The fact has been established that emotional turmoil can cause disease. The mechanism has been outlined, and the details are being filled in gradually. What many doctors formerly sensed has now become official. The first changes produced by stress are functional. If the functional disturbance is long continued, organic change follows.

We know also that two factors are involved in the production of emotional turmoil. One of these is the personality of the individual, and the other, the environmental pressures acting on that personality. Where—as some people are seemingly imperturb-

able, others are disrupted by the least trifle. The basic foundations for personality structure and stability are formed in infancy and childhood; later modifications are relatively superficial.

Both functional and psychosomatic diseases are very common in women today. Many cases seen in our offices belong primarily in this category, and almost all the cases we encounter have a functional component or "overlay." In women, a disproportionate amount of psychosomatic disease seems to be gynecologic. Stress which might produce, in a man, a stomach ulcer is likely to cause menstrual disturbances in a woman. The menstrual cycle is a sort of mirror, reflecting many of woman's disorders. I interpret this as consistent with the fact that reproduction is the tail that wags the dog in women.

Problem Women

Although most of my reading is medical, I am unable to avoid articles in lay publications on the subject of what is wrong with women. According to many articles, women are, in one way or another, ruining their children, not doing their share of the world's work, and pushing their husbands so hard that the husbands die off young. Not infrequently the articles insinuate that women produce these undesirable results wilfully or through lack of effort, or because they are intrinsically inferior human beings. Problem women and women's problems are almost in a class with the weather: Everyone talks about them and nobody does anything about them. The idea has occurred to me that this nonintervention prevails because women and their problems are just about as uncontrollable as the weather!

Fresh from reading such articles, I go to my office and there listen to women of all kinds and ages. I am a fine listener, because when I first got into this situation I didn't know anything else to do. Not in my home, or in public school, college, medical school, or postgraduate work was I trained for dealing with my own or other women's problems.

Now seems as good a time as any to cau-

tion you about my prejudices and to scrutinize the effect of my personality on this presentation. Selye's book, *The Stress of Life*¹, gave me not only an understanding of the mechanism producing organic disease from stress, but also a fresh awareness of the importance of the subjective elements influencing any observer. On page 5, Selye says: "It seems to me that most people do not fully realize to what extent the spirit of scientific research and the lessons learned from it depend upon the personal viewpoint of the discoverers at the time basic observations were made." I have discovered nothing, but my dealing with patients and my reading have been subjectively greatly affected by the fact that I am not only a woman but one type of problem woman. I had a terrible time growing up as a female, and had no understanding of my own problems. They had, in fact, been leading me around by the nose for years before I had any idea of what they were. I am still somewhat angry at a society that made of me, at least to some degree, a case of "rejection of femininity syndrome." It's very uncomfortable being schizoid, with a feminine type of personality for home and social life and a masculine type of personality for work.

Probably because I am a woman, patients know they can count on me for a sympathetic hearing. It is undoubtedly evident that I think women have essentially good sense and are capable of valid observations. I believe this is one reason that women come nearer telling the complete, unvarnished truth to me than they do to men doctors or to their husbands. In fact, they blurt right out and say so. Many a woman has told me, "I've been wanting to talk to a doctor about this, but I couldn't bring myself to ask a man"; or, "I told Dr. X that my sex relations were fine; I was ashamed to admit such trouble to a man"; or, "I don't want my husband to know about this. Mostly, we get along well and I wouldn't want to hurt him or have him think ill of me."

Women are particularly reluctant to discuss sex troubles honestly. At this time, 1960, in the U.S.A., men seem to value women more as sex partners than as mothers. Hence, women feel devalued and

threatened if they admit to any sex difficulties.

Out of their dependence on men—which dependence means potential or actual subservience in their dealings with men—women have found it expedient, possibly necessary, to misrepresent and distort. Sometimes their behavior is conscious, sometimes unconscious. Before you gentlemen react automatically with censure, consider for a moment how scrupulous you would be in presenting the absolute, complete truth to your boss if this truth was clearly going to have a bad effect on your status with him.

Women's Problems

Nearly all of women's problems, as I have observed and read about them, seem to go back in one way or another to men and children. Money provided by the men and needed for the children complicates most cases.

Woman's built-in, unchanging, primary role is the production of children. For this production job, men are necessary. In addition, they are intrinsically attractive as sex partners. Their importance to women is secondary only to that of children. In the production of children women find their greatest fulfillment and happiness. Their central problem is how to fit their primitive, unmanageable, unchanging function into the ever-changing—and at this time, fast-changing—environment of our complicated civilization.

Children (and reproduction)

Producing babies in the world today brings to woman a wide variety of problems which trouble her tremendously and get mixed up in many of her psychosomatic syndromes. In regard to child production, women are in a position not unlike that of wheat farmers. The law of supply and demand is against them. Women and farmers alike are plagued with surpluses which devalue their products. The population explosion that doctors have been hearing about for some time is now often in the public press.

Since contraception can usually be made

to work if one is willing to go to enough trouble, having babies is semi-voluntary for most couples. During pregnancy and while caring for small children, women are less able to do other work and are greater economic liabilities to their husbands. Children are almost pure economic liabilities. As a result, having a baby sometimes amounts psychologically, for a woman, to an expensive personal indulgence. It does not automatically accord her prestige, as was the case when children were economically valuable. Many women say, "I'd love to have another baby, but my husband says we can't afford it." Catholic women, with the prestige of the Lord's will behind their baby production, have a notable serenity.

Case 1 illustrates the devastating effect of a miniature "population explosion" in a family of limited means. It illustrates also the usual inextricable interrelationship of children, sex (men), and money in producing one woman's problems.

Case 1

Mrs. A. was a 33 year old married mother of four children. All her physical and laboratory findings were within normal limits, and the general history was noncontributory.

These were her presenting complaints: (1) "I have turned against my husband, not just sexually, but in every way. He's an affectionate man, and I can't bear to have him touch me. When he comes near me, even though I try not to show my feelings, I can't help drawing away." (2) "For two weeks I have been at the point that I cry all the time, and I don't know why."

Here is the background of her case:

In 1947 the patient, then a nurse aged 20, was married to a 23 year old student. In the modern pattern, she continued to work while he was still in school.

In 1949 they had their first child, a girl. The pregnancy was planned; pregnancy and delivery were normal.

In 1951 the second child, a boy, arrived. This also was a planned pregnancy and all normal. By this time the couple was settled in a small North Carolina town, and the husband, a professional man, was working as a salaried employee for a firm. They were happy.

In 1954 a third child, a daughter, was born after another normal pregnancy and delivery. This pregnancy had not been planned, but had resulted from a condom failure.

In 1958 the family acquired a new house, and to help pay for it the patient went back to work

as a nurse. "I would rather have stayed home with the children," she said, "but the youngest was 4 and it seemed to work out all right. We really needed the money." Here it came out that the husband's salary was inadequate, and that the advancement which had been implied, if not promised, when he came to the firm had not materialized. One could sense the predicament of this young man. He was saddled with a wife and family, and therefore was in no position to strike out on his own or to demand more money.

In July, 1960, the fourth child and third girl was born after a physically normal pregnancy and delivery. This pregnancy had emphatically not been planned, but was the result of a diaphragm failure. The patient was upset throughout the pregnancy, in spite of taking Miltown. She had to quit work, and financial worries were great. At the seventh month of this pregnancy her *present illness* began. She turned against her husband.

It is likely that the beginnings of the present illness go back to the beginning of the marriage. When this couple were first married in 1947, they were happy in every way, including their sex adjustment. As the years wore on, the patient felt proud that her husband seemed to find her sexually as attractive as when they were first married. "He's always been a once-every-night man except during menstruation," she said; and then, "From listening to my friends, I've learned that most couples don't have sex relations so often and I've tried to kid him a little about slowing down at our age, but he doesn't say anything. Until the last two weeks I've never talked to him about sex. I'm just plain scared to. I've always been crazy about him, and he is so good to me in every other way. After 13 years of marriage, we've been more in love and got along better than any other couple I know—until this trouble started."

On the standard schedule of intercourse every night the patient had been responsive and reached an orgasm about a fourth of the time. The other three fourths of the time, she hadn't minded, had been more or less neutral. Intercourse during the last unwanted pregnancy had been three times per week until the onset of the present illness at the seventh month. Since delivery, the patient's libido and sexual responsiveness had been gone, absolutely and completely. And, as before noted, she had reached the state where she cried all the time and cringed if her husband tried to kiss her or touch her hand. Her doctor at home attributed this changed attitude to fear of pregnancy, and recommended that she have her tubes tied. She did not want to have this done in her home town where everyone would know of it, and had therefore come to Durham to arrange for the operation.

I did not do a tubal resection for this woman. I didn't think a tubal resection

alone would cure her. But if I had thought so, I couldn't have done one. Two consultations are required before a tubal resection can be done in Watts Hospital, where I work. This regulation and many others pertaining primarily to women and pregnancy are imposed, usually, by elderly males so far past personal involvement that they have forgotten what such problems are like! This is, in a way, regulation without representation. Population explosion or no, we go right on forcing many women to have babies they don't want. I quote from Karl Menninger, who was writing about the psychiatric aspects of contraception, but whose remarks pertain here also:

The reason that contraceptive knowledge and counsel seem to the psychiatrist to be essential is based not upon considerations of the welfare of the adult, but upon the consideration of the *welfare of the child*. Nothing is more tragic, more fateful in its ultimate consequence than the realization by a child that he was unwanted.²

I really don't know whether our laws and customs in this area could be improved. I suspect that they need re-evaluation. Many great changes have come about since these rules were formulated. I feel absolutely sure that in many individual instances they impose undue hardship. The law requiring that silver nitrate be put into the eyes of newborn infants is a simple example of how legislation may lag behind progress.

Men (and sex)

I need waste no time elaborating on the relative values of children and sex in the marriage discussed in case 1. The case is a rather extreme example of the predominance of one male's pattern of sexual behavior, with total disregard of the female involved. In my opinion, the inability of a husband and wife to talk about sex matters was formerly more common than it is today. I think it is always undesirable. With sex education still a hot potato and in general badly managed, how can a man or woman who can't discuss the subject know how the mate feels? The premarital interview offers the best opportunity to prevent this undesirable handicap. Usually the bride is the only one to whom I have the opportunity

to talk, but I make a point of stressing to her the desirability of communication. After all, the sex technique of any couple is a highly individual matter perfected to a large degree by trial and error, sometimes with and sometimes without "book learning."

I believe that women's sexuality is tremendously affected by psychologic and sociologic factors. One trouble with human females is that they can think, and remember, and predict what lies ahead. The case I have presented demonstrates late psychosociologic damage; there is also a biologic factor with which I will deal later. If there had been plenty of money, the last baby would likely have been completely welcome and the patient would have continued to accommodate to her husband's sex pattern without too much trouble.

Usually, cultural damage to female sexuality comes earlier. The fear of illegitimate pregnancy is great in the parents of female children. Repressive conditioning starts early, and in many cases is unduly thorough. I've heard my partner, Dr. Richard Pearse, say, "Preparation for marriage begins at birth." The necessity for control of the sex activity of young people derives obviously from the lag of economic maturity five to ten years behind biologic maturity. All civilizations have found control necessary. A clear understanding of the dilemma helps young people who are semi-desperate with the urgency of their sex drives. And girls can understand readily why the main burden of policing falls on them, since they are the ones who risk economic incapacity and social censure through illegitimate pregnancy. The girl who understands *that* she has, and *why* she has, a culturally imposed handicap in responding sexually does not fall flat on her face psychologically during her honeymoon, even though her sexual initiation does not measure up to the expectations she may have derived from fairy tales, movies, and popular love songs.

The premarital examination offers a real opportunity to prevent difficulties in sex adjustment. Since sex difficulties are very often a factor in psychosomatic gynecologic dis-

orders, it follows that the premarital interview is an opportunity in preventive medicine. We do a little better than formerly, but we still do badly with the sex education of the young. In the early nineteen-forties a confidential investigation of the parents of college students showed that, for one of every three married women, sex relations were an ordeal to be avoided if possible. This brings me to case 2, not yet fully developed, but already perilously close to being hopeless.

Case 2

Mrs. C., a married nulligravida, was an exceedingly attractive young woman. She came because of sex troubles that had existed throughout the two years of her marriage. The patient's mother and father, both aged 40, got along well. The patient was an only child. Her mother had told her of menstruation before it started, and just before her marriage had talked with her a little about sex relations. When the patient was 11, the little girl next door "told me some awful things and Mother had to straighten me out." When she was 16, a male friend of the family tried to make advances. At 17, while she was living as a soldier's bride in a trailer near an army camp, she was terrified when a soldier neighbor, a former psychiatric patient, tried to rape her.

She had had no premarital pelvic examination; the doctor who signed her health certificate checked her heart and did a blood test. After marriage, intromission required two months—harrowing months for the patient. She was conditioned to dread sex relations. At her husband's approach she became tense, pale, and trembling, and she put him off whenever possible—usually for two or three weeks at a time. "I just don't care a thing about it," she said. Otherwise, she got along well with her husband. Her physical findings were normal except that she resisted, trembled, and actually wept during pelvic examination.

I suspect that this case is one of the relatively uncommon ones where a correctable anatomic condition, a resistant hymen, was an important factor. I have had little or no luck with cases of such long duration as this one. I tried to get her to go to a psychiatrist, but she didn't do it; "Johnny says no"—Johnny being her husband, of course. Even a psychiatrist working dozens of hours might not have been able to help her, but a fraction of the psychiatrist's time spent in providing more enlightened sex education, plus a good premarital examination and in-

interview, would almost surely have prevented her trouble.

Freud, in his book, *Civilization and Its Discontents*, expressed eloquently the need for a change in the education of young people:

That the upbringing of young people at the present day conceals from them the part sexuality will play in their lives is not the only reproach we are obliged to bring against it. It offends too in not preparing them for the aggressions of which they are destined to become the objects. Sending the young out into life with such a false psychological orientation is as if one were to equip people going on a Polar expedition with summer clothing and maps of the Italian lakes. One can clearly see that ethical standards are being misused in a way. The strictness of these standards would not do much harm if education were to say: 'This is how men ought to be in order to be happy and make others happy, but you have to reckon with their not being so.' Instead of this the young are made to believe that everyone else conforms to the standard of ethics, *i.e.* that everyone else is good. And then on this is based the demand that the young shall be so too.³

Some time back, I dealt with the need for young women to understand the effect of our culture on their sexuality. A bride needs also to have a clear understanding of her husband's sex problems in early marriage. His is the main performance, of tremendous importance to him; and he is obliged to face it without optimal experience, since women of the type he would be willing to marry are not readily available for practicing purposes. This is *his* culturally imposed handicap. In some cases, at least, a bridegroom will be nervous and have less voluntary control than he will have later after more experience. This is readily understandable, but not well known to young girls; neither do they realize ordinarily how sensitive men are likely to be with regard to sex performance. A bride needs to know these things; if she doesn't, she can inadvertently cause her husband great distress. Further, she needs to know specifically that her husband can best acquire skill in pleasing her sexually if somehow she lets him know how she feels—that is, which of the techniques he tries are most effective for her.

Both partners need to know that sex re-

sponses are to a considerable degree involuntary. One cannot be aroused or respond at will any more than one can decide to digest a dinner quickly or have the heart beat slowly. In so far as different individuals are concerned, this fact is well known. Every male knows why he doesn't whistle at the homely girls on a street corner. That the sexual responsiveness of females should vary during the different phases of the menstrual cycle is reasonable, but not well known to men generally. "*La Donna e mobile*" is built in. We know that in animals mating behavior is correlated with hormone titers and physiologic readiness for pregnancy. If a human female were raised in the woods like a lady Tarzan, the chances are that she would go into heat like any other female animal. Human habits being what they are, she merely notices that at some time she feels more responsive than she does at other times.

I have had several cases of normal, well-adjusted girls sent by their husbands for the sole purpose of finding out why they didn't want to have sex relations as often as their husbands. Most young people don't think through the fact that monogamous marriage has evolved from economic and sociologic pressures, and is not ideally suited to the sex needs of either males or females. Women, realizing the importance of sex to men, try very hard to compensate for this discrepancy. Nevertheless, some of them report that sex relations are a trial during pregnancy and lactation.

How well women get along with intercourse under unphysiologic conditions depends tremendously, again, on psychologic and sociologic factors. When her physiology is inappropriate, a woman is likely to be unable to respond sexually if she doesn't like her husband, or feels that he has let her down or can't take care of her if she gets pregnant, or that he is behaving at the moment like a stinker. Sometimes these considerations have an effect potent enough to block responsiveness altogether, regardless of physiology. In one case, I finally traced a breakdown in adjustment back to a fight in which the husband sided with his mother against his wife. In a recent case,



A vine, someone said, is like the human mind—always reaching out for new things to grasp.

PROGRESS...

One way or another people will seek out new ways to cope with old problems. Yet progress must be wisely guided. One doctor says: "The desire of the public to have prepayment medical protection is so urgent that it will buy this protection from whatever plan seems most enticing. Whether you like it or not, prepayment medical care is here to stay. Let us support the system which is voluntary and over which we have adequate control." **BLUE SHIELD**



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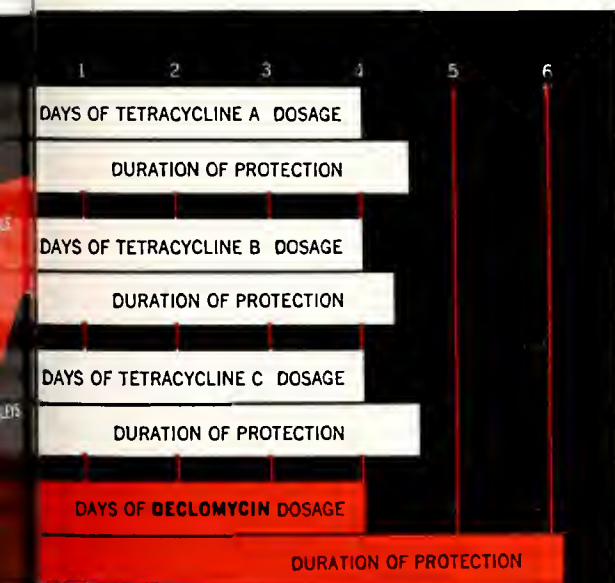
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5,000	7,500 to 15,000	75.00 Weekly	114.00	57.50	152.00	76.00
5,000	10,000 to 20,000	100.00 Weekly	150.00	75.50	200.00	100.00
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the breakdown followed the husband's second attack of rheumatic heart disease—an incapacitating one which would have made another pregnancy a disaster. The direct effects of poor health and fatigue are too well known to require comment, although the latter is often overlooked.

Money (and part-time motherhood)

Some problems seem to be intrinsic to the part-time motherhood pattern which has evolved as a compromise between world economic pressures and women's continued desire for children. A woman who realizes that she can have only one or two babies gets the feeling that she must do a perfect job on the ones she has. Before she can be convinced that this goal is impossible, she has usually done considerable damage to her first child. Trying too hard makes her tense and has an effect exactly opposite from the one she wished. As with any other job, experience brings skill. A woman gets to be a better mother after she's had a child or two—but by that time, nowadays, she's through. There is no trouble more devastating to a woman or better calculated to make her functionally ill than trouble with a child or children. One of my patients has had upset menstrual periods for the past two summers. When I asked her about worries and troubles, she admitted shamefacedly that her rebellious late-teen-age son was about to drive her crazy. She could hardly wait until he went back to school.

When to have babies is a second problem associated with part-time motherhood. Economic considerations dictate postponement. Biologic considerations favor not waiting. The girls who wait for a convenient time risk infertility, a higher incidence of obstetric trouble, and a greater risk of fetal abnormality. About 10 years ago, speaking to the Duke medical students, Dr. Dougald Baird, world-famous professor at the University of Aberdeen, made this statement: "If I were assigned by Stalin the job of preventing pregnancy wastage [failure while working for Stalin meaning, of course, one's job and/or survival], I would require that every woman have one baby before the age of 20, three more before the age of 30, and then

stop."

Economic pressure is usually the main difficulty for the girls who go ahead and have babies while they are young. Husband-wife controversy produced by economic difficulty not infrequently demoralizes the husband and may destroy the marriage. Economic problems doubtless contributed to Mrs. G.'s difficulties with marriage and motherhood.

Case 3

Mrs. G. was a 36 year old divorcee, the mother of three children. Her general physical and laboratory findings were normal. Her pelvis was anatomically perfect. Since 1951 she had had episodes of intermenstrual and excessive menstrual bleeding. She required a dilatation and curettage in 1954, and another in 1955. Normal endometrium was reported both times, and her Papanicolaou smears have been normal. For a long time she has been just short of being overwhelmed by emotional and environmental troubles.

She was an only child. Both parents were living, and emotionally dependent on her. When the father was forcibly retired, her parents moved to the same town where the patient lived, and her mother continued to try to tell her what to do. This the patient resented. Said she: "I didn't like the way I was raised. They were very Victorian about me. I went through the depression with them. I didn't even get through high school—didn't even have that chance."

In 1940, at the age of 16, she married and had her first daughter. A second daughter was born in 1942, and a third in 1945. In 1947 she left her husband because of his gross infidelity and because he was "irresponsible, inconsiderate, and unfeeling." She didn't want her daughters exposed to him.

Before judging, one needs to know both sides of a controversy, and unfortunately we don't have the husband's story. As the patient spoke of him, her terrific resentment was still evident. He contributed nothing to the support of the children, and she didn't know where he was. Since 1947 she had been working 40 hours a week to support herself and the children, and had managed to work into a pretty good business situation. From 1951 to 1960, she reacted to crises by the menstrual disturbances already mentioned.

The past year had been really grim: In November she had a cholecystectomy for stones. In February her parents moved to town. Spring brought the fear that her second daughter, 18 years old, was going to marry an irresponsible boy. (Parents always fear for their children those hazards which have been significant in their own lives.) In July she discovered that this daughter was illegitimately pregnant. The other girls, aged 15 and 20, had taken the situation

calmly, but the patient dreaded having her parents learn of it. When she came this fall for her gynecologic check, there were new stress reactions: She smoked two packages of cigarettes per day, and averaged two Miltowns per day; she had had diarrhea all summer; her blood pressure was up from 110/70 to 130/90. Two days previously, she had been forced to quit work because of brief dizzy spells and a tight feeling in her head.

Motherhood in Our Culture

A significant number of books say that our culture is unfavorable to women and motherhood, and that this is so because it has been created and dominated by males. I quote from Georg Simmel, a German philosopher:

Our whole civilization is a masculine civilization. The state, the laws, morality, religion and the sciences are creations of men . . . all these categories belong as it were in their form and their claims to humanity in general, but in their actual historical configuration, they are masculine throughout. Supposing that we describe these things, viewed as absolute ideas, by the single word "objective," we then find that in the history of our race, the equation, objective = masculine, is a valid one. The reason that it is so difficult to recognize these historical facts is that the very standards are not neutral. Inadequate achievements are called feminine, whereas distinguished achievements even by women are called masculine.⁴

From this Simmel does not deduce, as is commonly done, an inferiority of women, but he goes on to say:

The greater importance attaching to the male sociologically is probably due to his position of superior strength . . . Historically the relation of the sexes may be crudely described as that of master and slave. Here, as always, it is one of the privileges of the master that he has not constantly to think that he is master, whilst the position of the slave is such that he can never forget it.⁴

Recently, a new theme is to be found in books dealing with social problems—namely, that our culture's interference with the primary mother-child unit has had a boomerang effect on everybody. Some books allege that bad mothering resulting from unfavorable cultural pressures has caused the higher incidence of neuroses, psychoses, juvenile delinquency, and crime. James Clark Moloney, an American psychiatrist, has written several books on the subject. Here is the opening statement from his book entitled

Fear: Contagion and Conquest:

My thesis is that emotionally stable, normally integrated, emotionally mature adults develop by being afforded properly measured mothering by relaxed loving mothers throughout the first three to five years of their lives. And further my thesis is that normal, non-neurotic mothers made tense by *real dangers* can inoculate their babies with their own normal fears and thus cause their babies to grow into neurotic adults . . .⁵

In another book, *The Battle for Mental Health*, Moloney says: "It is not that the neurotic woman *will not* afford her child love; the awful truth is that she *cannot* afford her child love, despite her conscious efforts (to comply with conventional requirements)."⁶

Most of the women who are our obstetric patients have had no preparation for motherhood. They are obliged to learn as they go along with the first baby. Except for marriage courses in a few universities, our educational system continues to ignore this problem. Effective action to meet this need and the need previously mentioned for realistic sex education is perfectly possible and would favorably affect motherhood and fatherhood.

Modern obstetric practice has been censured as one of the more important influences unfavorable to motherhood. We are accused of having made childbirth antiseptic, anesthetic, and emotionally unrewarding in the process of making it safe. These allegations are relatively recent. In my early years, I hadn't heard of them at all. Then the emphasis was on lowering maternal mortality by prenatal care and hospital delivery. This emphasis appealed greatly to me, for as a girl of 11 or 12 I had heard a woman in the other side of our duplex house moan for three days and then die without giving birth to her baby.

Experience on a hospital teaching service reinforced such feelings. Our service was loaded with abnormal cases—more often than not, bedraggled, dirty, worn-out specimens gathered from far and wide. Humanitarian considerations were not much in evidence. During the long hours of waiting, these women were treated impersonally by bored young doctors and by young nurses

generally more interested in the doctors than in the patients. The doctor was the star of the show. He had no time to wait around for the patient to be ready for delivery. She was given an anesthetic while she waited for him. When the doctor arrived, *he* produced the baby for the anesthetized patient.

I started private practice in 1942, and it brought me, in a shocking hurry, to a very different situation: the responsibility for high-class, normal obstetric patients. Male obstetricians in significant numbers were sent off to war. Suddenly, I found myself with friends, friends' wives, and my only sister as my obstetric patients. These friends started my education in the psychology of parturient women.

The natural childbirth movement was the next really important influence. I have never been convinced that natural childbirth is without pain. It seems rather that the women are so glad for the constant kind attention they receive that they don't mind their discomfort. No one who has seen a natural childbirth can doubt the emotional value of the experience to these women. It is possible, however, to use conservative methods of pain relief, and at the same time give a woman this feeling of participation and accomplishment. I have come to believe that, along with providing a safe delivery, we doctors have the obligation to try to help a woman do a good job in childbirth, and above all, to make her *feel* that she has done a good job. Here is the best of all possible chances to bolster a woman's self-esteem. Women are people, too, with a need to feel important. The average wife feels terribly unimportant.

Conclusion

The interns around our hospital used to say, "We're not paranoid; we *are* persecuted." What I have been saying is that women *do* have real problems, and that their problems derive largely from the cultural forces to which they are trying to adapt. Their built-in destiny, the major role in reproduction, is unchanging. As civilization advances, reproductive biology remains little modified. As socioeconomic factors take increasing precedence over biologic factors, women are disproportionately affected. The

geese that lay the golden eggs are having a hard time.

The need to remedy women's troubles is overwhelmingly important for children. The welfare of women and the welfare of children are inseparable. The need to remedy women's troubles is almost as important for men as for women, since the true welfare of one sex depends on that of the other. A woman who is a problem to herself is a problem to her husband and to her children.

Progress was impossible as long as women's problems were attributed to intrinsic peculiarities of the "weaker sex." There is hope of progress now that the finger of suspicion has been redirected toward the external forces which condition women's behavior. I believe that the problems plaguing women in this late twentieth century are worthy of serious study and, wherever possible, amelioration.

Actually there are signs that this enormous undertaking has started; but social change moves by decades, generations, or even centuries. For a long time we doctors will be seeing neurotically, functionally, and psychosomatically ill women. One such patient can disrupt both an office schedule and a busy doctor's perspective. Some patients seem not to justify extensive salvaging efforts. For dealing with them, I recommend a technique described by Dr. Hugh Matthews of Canton, N. C.⁷ If a serious effort is justified, the technique of Dr. Maurice Greenhill, formerly of the Duke University School of Medicine, will be better.⁸ Simple kindness is magic for all these troubled women.

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Better Care for the Mentally Sick

W. RANEY STANFORD, M.D.

DURHAM

I have long been interested in the care of the mentally sick. In fact, I spent nine years on the Dix Hill Hospital Board during the time when the patients there received little more than custodial care. By a little exaggeration you could almost say that for these poor afflicted people the doors of these institutions opened only one way. In those days most of the money that was appropriated was spent on brick and mortar. I have hoped for a long time to see a new day dawn for the inmates of these institutions. I am sure that if one looks carefully one can see the beginning of light in the east, but there are still many things to do. It would seem proper to make some suggestions that might hasten the coming of this day.

First, we should set up a proper wage scale that would enable the doctors who work in these institutions to give their time and skill to the study and treatment of the patients without worrying about security.

Second, we should set up an adequate postgraduate training program for the doctors who practice in these institutions (a rotating type of instruction) so that these young men shall be adequately taught. Along with this postgraduate teaching program we should encourage resident training in these institutions. A well informed staff would be of great service not only to the young doctors themselves but to the patients. If such a program were instituted, within 5 or 10 years North Carolina would have a psychiatric program that would rank high in quality among the states of the union.

Most doctors know that psychiatric methods in common use are serving a great purpose and are making useful citizens out of many people who formerly would have been a total loss. One wonders, however, if we are really handling this situation in the most humane and sensible way. After all is said and done, many patients in

psychiatric institutions are still little more than prisoners. Of course, much is being done to make them happier and more contented — television, movies, books, and all sorts of entertainment are being provided; but still one wonders if we are really giving the type of therapy necessary to get them back into society as soon as possible. The thought that comes to my mind is not new. Dr. Burlingame, at the Hartford Retreat in Hartford, Connecticut, long ago set up what was called an Institute of Living. I do not know exactly how this institute was run, but the idea appeals to me. The concept that I get is something like this:

Wouldn't it help if we could get these people, especially the younger ones, in some institution where we could teach them how to live, how to play, how to work, how to be useful citizens again? Tests could be given to determine what they are fitted to do, and they could be taught how to do the things for which they are best equipped.

Such a program would be expensive, but we could start in a small way. To our drug therapy, to our physiotherapy, to our psychotherapy, to our psychoanalysis, and to all the other methods that psychiatrists employ, let us add a real occupational therapy program that would teach these people how to live.

I believe in all that is being done to reclaim our feeble-minded children, and I believe in all that is done to make life pleasanter and happier for our older people; but I wonder if we are doing enough for our adolescents and young adults who break when they first begin to meet the problems of life. These young people do not belong to our feeble-minded group. As a matter of fact, many have superior intelligence. They are just too delicately made and too sensitive to stand the stress and strain of modern living. Many of their problems are the creatures of their superior imagination. Of course, many of our middle-

aged and older patients come under the same category. In brief, we are allowing some of our very best brains to go to waste. I am convinced that a commonsense approach could reclaim a substantial number of these people; and even if we do not completely rehabilitate them, we would have the satisfaction of putting them more in tune with their environment and making them happier.

Report from The Duke University Poison Control Center

JAY M. ARENA, M.D., *Director*

LEAD POISONING

Part Two

The appraisal of the significance of lead absorption by means of analysis of the urine is much more difficult and much less effective than that of analysis of the blood, especially with children, in whom there is a wide physiologic variation in 24-hour urinary volume. Factors such as dehydration and acidosis, often accompanying the acute episode of lead poisoning in children, can alter the urinary output of lead in the untreated patient, so that the amount excreted may fall within the normal range. The collection of an uncontaminated sample of urine from a young child for the purpose of lead analysis is usually difficult, extreme precautions being required to prevent contamination of the urine with lead.

Administration of calcium EDTA to patients who have abnormal amounts of lead in their tissues is followed by a rise in urinary excretion of lead. This increased lead excretion following the administration of edathamil has been suggested as the basis for a diagnostic test. Patients receiving edathamil therapy should excrete 1.5 mg. or more of lead in the urine on any one of the first three days of treatment. This test, while by no means as satisfactory as that for the determination of the level of the urinary excretion of lead prior to any

therapy, may be more practical than the collection and analysis of a 24-hour urine specimen from an untreated patient where a delay in therapy is hazardous.

The stippling of red cells in the blood smear is often a better guide to lead damage than the blood or urine lead level. Stippling may be absent in the rare cases of sudden massive ingestion of lead with a rapid onset of symptoms, but usually more than 20 stipple cells per 50 oil immersion fields are present in lead poisoning, and serial determinations show an increase of stippled cells as poisoning becomes manifest.

Recently it has been reported that observation of red fluorescence in erythrocytes examined under ultraviolet light is a simple reliable means of detecting lead poisoning. From 75 to 100 per cent of the erythrocytes were fluorescent in thin wet-drop preparations of heparinized blood in a group of children with untreated lead poisoning. Less than 51 per cent fluorescence occurred in erythrocytes from healthy subjects and patients with various diseases.

Glassware and other equipment used in the collection and analysis of blood and urine samples can and should be rendered free of any possible contaminating lead by rinsing with a warm 20 per cent solution of citric acid, followed by thorough rinsing in "lead-free" distilled water. Other special precautions must be taken in the laboratory to prevent contamination of the samples from lead-containing airborne sources during ashing and analysis.

Exposure to a Lead Source

Childhood lead poisoning is, in general, a disease of poverty, almost always found in areas of old, run-down housing. The source of lead is usually lead pigment paint applied and re-applied early in this century, to walls and fixtures which more recently have been neglected and allowed to fall into disrepair. These coats may be buried beneath other coats of paint, covered with wallpaper, or may cover wallpaper or plaster. With neglect, the paint and painted wallpaper peel, and the painted plaster crumbles. Particles may then be picked and ingested by young children. Lead paint in

good condition has been chewed off of surfaces also. An adequate safe substitute indoor paint was not made available until about 1940. Lead paint applied to outside surfaces has also been known to be the source of lead in cases of childhood plumbism.

Children's toys and furniture are not significant sources of lead unless repainted with lead pigment paint. Since 1955 the American Standards Association has recommended that only paints with a lead content of 1 per cent or less may be considered safe for use on children's toys, furniture, and in housing interiors.

Other sources of lead should be kept in mind. Numerous cases of poisoning have occurred in both children and adults from inhalation of lead fumes and exposure to ashes resulting from the burning of lead storage battery casings for fuel, a practice sometimes resorted to by destitute families.

In most cases of childhood lead poisoning, pica, the abnormal appetite for non-edible substances, is responsible for lead being taken into the body. Children, usually between the ages of 1 and 5 years, most often exhibit this abnormal appetite, which may result from emotional disorders or nutritional deficiency. It has been shown that lead is retained in small amounts in the tissues of an adult with a daily intake of 1 mg. of soluble lead in addition to the normal daily dietary intake (0.2-0.4 mg. of lead). Since lead pigment-containing paint peelings may contain 100 mg. or more of lead, the repeated ingestion of small amounts of these peelings is compatible with absorption and retention of dangerous quantities of lead in the tissues. This will eventually result in clinical manifestations of poisoning if the exposure is not interrupted.

Diagnosis

A positive history of pica for paint and a roentgenogram of the abdomen demonstrating radio-opaque material in the intestinal tract are valuable clues to the ingestion of lead. A history of ingesting paint chips or chewing on walls or woodwork may or may not be obtained. Often

such activity goes unnoticed, or the amount ingested is considered insignificant by the parents. The history may be obscure, incomplete, or fragmentary. The possibility of the existence of lead poisoning, therefore, must occur to the physician from the nature of the illness itself, and he must be prepared to make a presumptive diagnosis in an acutely ill child without an elicited encephalopathy, into lead poisoning with mild and lead poisoning with severe encephalopathy. The latter group should include those patients who have convulsions or who are comatose for 24 hours or longer.

The long-term prognosis of childhood plumbism with reference to mental and neurologic function may depend upon the severity of the acute symptomatic episode. Therefore this classification should be of prognostic value.

The above diagnostic classification is also suggested in order that children who are ingesting abnormally large quantities of lead and children with lead poisoning without encephalopathy will not be overlooked. Early diagnosis is essential for a good prognosis in this disease. Removal from lead exposure and therapy with calcium EDTA will more often result in a favorable outcome if instituted early. Therapy with calcium EDTA is not as effective once acute lead encephalopathy has occurred. This very effective drug has not significantly reduced the 10 to 15 per cent mortality rate from lead poisoning in children, because more often than not therapy is delayed.

(To be concluded.)

The family dog or cat may well be a carrier of diarrheal disease according to information presented in the current issue of **Patterns of Disease**, a Parke, Davis & Company publication for the medical profession. The report cites the results of tests conducted among family pets which revealed that 14% of dogs and 8% of cats were infected with *Escherichia coli*, a bacteria associated with diarrheal disease in infants. This type of diarrhea is particularly common among newborn babies and **Patterns** suggests that "in hospital outbreaks of infantile diarrhea, infection may be brought into the nursery by an infected mother or nurse who has been in contact with an infected pet".

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HARPER'S CRISIS IN MEDICINE AGAIN

The January issue of *Harper's Magazine* contained a "Roundup of Comments" on the October Supplement, "Crisis in Medicine"—together with the announcement that the Supplement with new material added would be published in book form in March. The editorial foreword stated that "Space permits publication of only a fraction of the many thoughtful and informative comments which were still arriving as this issue went to press. Since our authors have had their say, we give the floor mainly to those who differ with them." A fairly careful analysis of the 18 letters published, however, reveals that 9 agree, 9 differ. And of the 9 letters in opposition 3 take issue with Mr. Russell's article on research, which was one of

the least critical of the medical profession.

The publication of the "Roundup of Comments," to be followed by a book on the subject, will probably mean that many patients will be asking their doctors questions about it. In order to furnish some ammunition for the medical side of the argument, an exchange of letters between the Editor of the NORTH CAROLINA MEDICAL JOURNAL and the editorial staff of *Harper's* is published in the Correspondence Department of this issue.

It is apparent from the first letter of Mrs. Sanders that *Harper's Magazine* does not want to give equal time (or space) for discussion of the most controversial of the Supplement articles.

* * * *

INTERNAL MEDICAL AUDIT

All national banks are required by law to have, in addition to inspections by official bank examiners, at least one annual "internal audit," conducted by selected members of its own staff. The leading editorial in the December *Journal of The Oklahoma State Medical Association* by Dr. Don W. Branham tells in some detail how hospitals might well profit by internal medical audits. Dr. Branham's editorial was based on a recent three-day session in Denver of a group of departmental heads, hospital administrators, librarians, and other professional personnel. The meeting was sponsored by the Colorado School of Medicine.

Such an internal audit would go far beyond the function of a "tissue committee." "The committee acts only as a fact-finding group for the staff, it does not attempt a review of everything on a clinical record, and tends to limit its examination of the records to finding an answer to one or more hypothetical questions asked about the particulars of hospital management for those disease conditions which they are auditing. For example: is antibiotic therapy used carelessly in certain disease conditions; or is the laboratory being over-utilized; or are there not enough laboratory tests to properly manage certain diseases?"

No doctor would audit his own records.

If any marked error in judgment were found, a committee would confer with the doctor in charge of the patient. If the facts warranted, the case would be referred to the hospital staff or the board of trustees. The function of the auditing committee would not be to punish but to educate.

The idea of an internal audit at regular intervals is certainly worth considering for most hospitals. In the larger hospitals each department could profitably conduct its own audit.

Dr. Branham concludes his editorial with the somewhat depressing but unfortunately realistic statement: "With the approach of more and more socialization in the practice of medicine, audits of hospital records will become more and more important, for it stands to reason if a third party begins to exercise more authority in the field of health care, medical audits of clinical procedures will become necessary. If a staff then does not audit its own hospital work, a third party will take over the responsibility. And if a staff permits a third party to audit how they practice medicine, they will have no one but themselves to blame when they lose their freedom in the practice of medicine. An Internal Medical Audit Committee in a hospital is an important safeguard to prevent this loss of freedom."

* * * *

A LAY SERMON

In a recent discussion of race relations, a prominent manufacturer made a statement that was a sermon in itself. Various theories had been advanced to explain the widespread prejudice against Jews and Negroes. Freud, Reinhold Niebuhr, and other psy-

chiatrists and theologians had been quoted at length. Finally, this business man said something to this effect: "I don't see why we need go into such deep water in our thinking. It seems to me that the psychiatrists and the theologians confuse rather than clarify the issue. Christ's teachings were so simple that they should be accepted and practiced just as he meant for them to be. By actually practicing Christ's teaching, Mahatma Gandhi, with his loin cloth and goat's milk, subdued the British Empire. By using the same methods of nonviolent resistance and by refusing to meet force with force, Martin Luther King and his followers have won for the Negroes far more than they could have done had they met violence with violence. Can we do any better than to follow their example, and in all sincerity carry out Christ's teachings? This plan will work in business as well as in other fields."

In the last two verses of Matthew, Christ's parting message to his disciples is referred to as the Great Commission. The first part, "Go ye, therefore, and teach all nations, baptizing them in the name of the Father, the Son, and the Holy Ghost," is often quoted as authority for missionary work.

The second injunction, though it is too apt to be overlooked, is equally important. It might have served as a text for the business man's lay sermon: "Teaching them to observe all things whatsoever I have commanded you: and, lo, I am with you always, even unto the end of the world."

Did not this business man — who really practices in his organization what he preached to this discussion group — offer the real solution of the world's problems? Certainly, his remarks are quite appropriate for the New Year — and for the years to come.

The rewards of this habit of worrying are great. It enriches the life of the physician. He then knows he is the type of physician we ourselves would like to have when we are sick. Concern about his patients after he leaves the sickroom is the physician's service beyond the call of duty. It is this type of doctor who does his job uncommonly well.—Levine, S. A.: Worry—Where Will It Get You? The Pharos 23: 216 (Oct.) 1960.

President's Message

WHITE HOUSE CONFERENCE — ESSENTIAL FACTS

The following quotation is taken from the lead editorial of the *New York Times* of Thursday, January 12, 1961. This editorial opinion was expressed either editorially or in by-line articles in essentially every newspaper in the country during or immediately upon the conclusion of the White House Conference on Aging.

"Health protection for the elderly, provided through the existing Federal Social Security system, has been given great impetus—as it should—by two developments this week. The first was its impressive endorsement by participating groups in the National Conference on Aging and the second was the report of President-elect Kennedy's special task force headed by Wilber Cohen, Michigan University Professor of Public Welfare Administration. Especially notable was the action taken at the Washington meeting attended by 2,700 leaders representative of the medical profession, social welfare agencies, business, labor, education and insurance.

Six of seven work groups dealing with the problem approved the use of the Social Security system, while the whole section voted 170 to 99—all in spite of a campaign by the American Medical Association against the Social Security approach. These actions were a victory, political and otherwise, for those, led by the President-elect, who are insistent on immediate amendments to the Social Security Act to give health protection to older people."

This opinion, which was the expression of some less than 300 or approximately 10 per cent of the total delegation attendant at this conference, was fostered as the thinking of a majority of the 2,700 delegates who formulated the policies which will be expressed as recommendations from this conference to the President and the Congress of the United States. As one of these 2,700 delegates and a doctor of medicine, I would like to express to you some thoughts and opinions gathered during this four-day national session. This I will attempt to do in a manner as far from emotion, bias, and prejudice as is possible under existing circumstances.

The meat of the conference recommendations, as reported in the press, radio and television, dealt with the mechanism of

financing health care for the aging. The problem of discussion and solution of this proposition was assigned to seven work groups constituting one of twenty sections of the conference, each with a special problem area of its own. By virtue of a special request and some maneuvering I was assigned to one of these work groups. Therefore most of these observations which I pass on to you must be relevant to this area of discussion.

In these work groups the cold issues involved were soon in evidence. The paramount issue was exactly this—Is medical care, as a service of the Federal Government, presently the right of all people 65 years and over, and ultimately the right of all people, regardless of age, in the United States? Very little time and tears were devoted in these sections to the "sad plight" of the "Senior Citizens." On trial was a philosophy of government, and the recommendation resultant was not by chance. I would say that our Senior Citizens received as much conscientious consideration in these discussion groups as does the pig who dies to supply the skin to cover the football which is kicked around before 60,000 spectators on a given autumn Saturday afternoon.

Throughout the entire conference propaganda was disseminated effectively by officials connected with this conference through all communications media to the effect that the A.M.A., a great union and lobby force, had stacked and rigged the conference in its favor. In fact, Senator McNamara from Michigan, in his address before the opening Plenary Session, openly and frankly accused the doctors in general and the American Medical Association in particular of putting personal desires above the care of the aging and of rigging the conference to accomplish this end. This statement brought much applause from a majority of those in attendance. This propaganda was effectively "sold" to many naive delegates and a majority of average citizens.

Let us return now to the work group

which I attended. To this group were assigned 33 delegates. After several hours of much discussion pertinent to how medical care, as a service of the Federal Government, can be supplied to people 65 and older, to the neglect of ever establishing evidence of need or desirability, a vote was taken on the issue. By a vote of 17 to 12, with 2 absent and 2 abstaining, it was recommended by this group that federal care for the aged be implemented through the mechanism of the present Social Security system.

In order to understand this vote, let us analyze those who voted and thereby establish a composite picture of this group. My analysis, not officially documented, shows that in the 17 votes cast for the motion the following segments of America were represented: 5 officials of large national labor unions; 2 representatives of "Senior Citizens"; 3 college professors; 1 clergyman; 1 medical doctor; 1 Social Security Administration official; and lastly, a group of 4 who were welfare officials and state politicians. Voting against the motion were 4 medical doctors, 3 officials of the insurance industry, 2 representing private enterprise business, and 2 non-descript. Of the 4 non-voters, it is my opinion that their vote would have been equally divided on this issue.

My work group (I-2) had as chairman Charles E. Odell, Director of Older and Retired Workers Department, United Auto Workers, AFL-CIO, Michigan. His vote on the major issue—*yes*. Discussion Leader Wayne Vasey, Dean Graduate School of Social Work, Rutgers University, New Jersey. His vote—*yes*. Recorder, H. Horace Leavey, Vice president and General Counsel, California-Western States Life Insurance Company, California. His vote—*no*. Resource, Herbert Natkin, M.D., Medical Director, Onandaga Department of Public Welfare, New York. His vote—*yes*. Also Resource, Charles E. Hawkins, Legislative Reference Officer, Social Security Administration, Department of Health, Education and Welfare. His vote—*yes*. Also participating quite vocally in this group was Miss Loula Dunn, Director, American Public Welfare Association, who, in a recently published talk "voiced the support of the

association for the present medical care program (Kerr-Mills Act), but stressed that it is only a first step to a really comprehensive program under Social Security."

The Honorable Robert W. Kean, Chairman of the National Advisory Council, who had total charge of formulating this conference in its every detail, even down to who was assigned to each individual work group, honored our work group by his presence during our discussions throughout the day. At the conclusion of the work group sessions their 7 individual recommendations were assembled into a final composite report to represent the recommendations of this section under the direction of Charles I. Schottland, dean of the Florence Heller Graduate School for Advanced Studies in Social Welfare, Brandeis University. Dean Schottland is a member at large of the Board of Directors of the American Public Welfare Association.

I belabor the structure and personnel of this work group and section not without purpose. In six of the seven work groups charged with making this important decision that aid to the aged be implemented under Social Security facilities the distribution of the participants as to background and affiliations was the same. The vote in each of these six work groups percentage-wise, was essentially the same. The mathematical probability of this distribution, with its resultant recommendation, on a basis of chance, is most remote indeed. One work group in this section was allowed a different personnel structure. In this group was Dr. Ludwig, Chairman of the A.M.A. committee charged with this area of A.M.A. activity. By deliberate intent, I believe, this work group was permitted personnel to return a majority vote opposed to the Social Security approach to the problem. This maneuver, no doubt, was calculated to appease and allay suspicion.

Other of the remaining 19 sections of this conference, which were neither charged with *nor permitted* to discuss and recommend on the all important issue of financing medical care for the aged, were in instances, stacked and rigged under the direction of the same master manipulator, Chairman Kean,

so as to produce recommendations of minor importance favorable to the established viewpoint of the American Medical Association. Then—the master stroke; in much the same propaganda line as Castro shouts threats of “American Yankee Invasion,” or as along the same line when Russia is ready to commit aggression she loudly and vociferously accuses her enemies of aggression, Senator McNamara, that stooge of unions from Michigan, shouts to the world that the A.M.A. has rigged the conference. The sad conclusion of this story is that a great majority of Americans have “bought” and firmly believe this accusation to be factual. The prestige of American physicians as organized groups is at a low ebb.

Well over one hundred years ago, in his treatise “On the Duty of Civil Disobedience,” Henry David Thoreau wrote: “The American has dwindled into an odd fellow, one who may be known by the development of his organ of gregariousness, and a manifest lack of intellect and cheerful self-reliance; whose first and chief concern, on coming into the world, is to see that the alms-houses are in good repair; and, before yet he has lawfully donned the virile garb, to collect a fund for the support of widows and orphans that may be; who, in short ventures to live only by the aid of the mutual insurance company, which has promised to bury him decently.”

Can it be that this great philosopher, who wrote the blue-print for the overthrow of many governments recently, who said that in America “There are many professors of philosophy—but few philosophers,” foresaw the eventuality of a great group of citizens meeting in Washington, under government sponsorship, recommending that the United States Government follow the line of basic Marxist philosophy: From him who has, according to ability—to him who has not, according to need—by force of government? Indeed, a strange philosophy of government is upon us.

Amos N. Johnson, M.D., President
Medical Society of the State of

North Carolina
Garland, North Carolina
January 14, 1961

Correspondence

EXCHANGE BETWEEN EDITORS

September 29, 1960

The Editors
HARPER'S MAGAZINE
New York 16, N. Y.
Dear Sirs:

I have just read with great interest the Supplement to the October HARPER'S, “The Crisis in American Medicine.” I am writing to know if you would be interested in an article attempting to answer the questions raised in the foreword. Some of the criticisms are deserved — but I believe that some are based on erroneous impressions.

As qualifications for writing such an article, I was a general practitioner for 10 years, an internist—family doctor—for an additional 20 years, and for 19 years have been Professor of Clinical Medicine at the Bowman Gray School of Medicine. I have also been Editor of the NORTH CAROLINA MEDICAL JOURNAL since it was started in 1940.

Incidentally, the first magazine article that I had published was in HARPER'S many years ago on “A Family Doctor Speaks His Mind.”

I don't want to waste time on preparing an article unless I feel that there is a reasonable certainty of its being accepted. Of course, I don't expect you to guarantee its acceptance, but at least would like to know if you could encourage me to try working on it.

With best wishes,

Sincerely yours,
Wingate M. Johnson, M.D.

* * *

October 5, 1960

Dear Dr. Johnson:

Thank you for your letter of September 29. Unfortunately our editorial plans make it unlikely that we would have space for the kind of article you propose for many months to come.

However, we do plan to devote a considerable portion of our letters column — and possibly a separate section in a future issue—to comment on our Medical Supplement. If you feel that you could convey some of your ideas in a letter of from 300-500 words we would indeed be happy to have it.

Sincerely,
(Mrs.) Marion K. Saunders
* * *

To the Editor
HARPER'S MAGAZINE
Dear Sirs:

The October Supplement, “Crisis in American Medicine,” must have been prepared to furnish material for the affirmative side of the National Collegiate Debate topic for 1960-1961, “Resolved, That the United States Should Adopt a Program of Compulsory Health Insurance for All Citizens.”

Space limitations will allow only brief answers to the five questions raised in the foreword.

(1) "Why are we up against a critical shortage of doctors—with no plans to fill the gap?" The answer is that we are not. Most statistics on the doctor-patient ratio hark back to the era before Abraham Flexner reported in 1910 the results of a two-year investigation of medical schools. As a result of the investigation—made with the approval and cooperation of the American Medical Association's Council on Medical Education—more than half the medical schools in the United States were closed. Since then the number of medical schools has been increased in keeping with the need.

Another consideration is that early in this century 70 per cent of the physician's working time was spent in going from one patient to another, leaving only 30 per cent to be devoted to his patients. Now only 10 per cent of the average doctor's time is used in transportation and 90 per cent with the patient.

(2) "Why is the old-fashioned family doctor in danger of becoming extinct?" The family doctor's funeral has been preached at intervals for the past century — but he refuses to stay buried. The American Academy of General Practice is the second largest medical organization in the United States. The "old-fashioned" family doctor with calomel, quinine, and mustard plasters has been replaced by modern well trained practitioners and internists.

A compulsory health program would do more to bury the family doctor than anything else I can think of. Great Britain's national health scheme has made the general practitioner really the low man on the medical totem pole there.

(3) "Why—in spite of their soaring charges—are our hospitals on the verge of bankruptcy?" Hospitals have never been considered profit-making institutions. It is true that much more expensive equipment in every department is now required. The 40-hour week and the 5 to 5½-day full operation make it cost far more to run a hospital than if it were run full-time. Even so, the cost is not greatly in excess of charges made in many hotels. Many hospitals are meeting the problem by graduating medical charges according to the amount of nursing-care required.

Because of medical and surgical advances, the average patient's stay in a hospital is much shorter and his chance of coming out alive much better than a generation ago.

(4) "How did both political parties become convinced that the government will have to do something about the rising costs of medical care for old people?" Because the politicians in both parties think in terms of votes—16 million people more than 65 years old.

Two members of the Emory University Department of Sociology and Anthropology reported last August at the Fifth Congress of the International Gerontology Association that

extended personal interviews with 1,500 non-institutionalized persons aged 65 or more revealed that more than 90 per cent of these older patients could think of no unmet personal medical needs; 64 per cent had medical insurance; and only 10 per cent believe that government insurance should be compulsory.

(5) "Why does organized medicine nearly always fight to the last ditch against changes that have been adopted long ago in virtually every other civilized country? And then, in the words of one observer, 'fall back from one unprepared position to another'?" This question is answered by the first statement in the foreword, "American medicine is the best in the world." Organized medicine wants to keep it so.

Wingate M. Johnson, M.D.

* * *

November 28, 1960

Dear Dr. Johnson:

Most unfortunately, your letter arrived after our January issue had gone to press. In it we are publishing a roundup of comment on the supplement and I believe most of the points you make are covered. We are very sorry your letter couldn't be included.

Sincerely,

Marion K. Sanders

New Prescription Tablet Controls All Cold Symptoms

A tablet that is highly effective against the different symptoms of the common cold, and is available on prescription only, has been made available to the medical profession by Winthrop Laboratories.

The new medication is called Win-Codin. It is a compound tablet containing five chemical ingredients which, in the opinion of Winthrop, has demonstrated outstanding results in controlling all the varied symptoms of the common cold in adults as well as children.

Win-Codin contains codeine, Neo-Synephrine, aspirin, chlorpheniramine maleate and ascorbic acid (vitamin C). Codeine combined with aspirin is known to be especially effective in treating mild and moderately acute pain, such as the headache and other aches and pains that often accompany acute coryza, influenza and sinusitis. Aspirin, of course, is the time-tested method for reducing the fever that usually is a symptom of many respiratory infections.

In addition, codeine relieves the dry, irritating cough produced by infections of the upper respiratory tract. Neo-Synephrine has a decongestive effect on the mucous membranes of the respiratory tract, while chlorpheniramine maleate is a potent antihistaminic. The addition of vitamin C to the Win-Codin formula is designed to counteract depletion of this vitamin which occurs in most infections.

Committees & Organizations

NORTH CAROLINA ACADEMY OF GENERAL PRACTICE

ANNUAL REPORT OF THE MENTAL HYGIENE COMMITTEE TO THE BOARD OF DIRECTORS

A meeting was called in May, 1959, between Representatives of the Mental Hygiene Committees of the North Carolina Academy of General Practice, the North Carolina State Medical Society, the chiefs of staffs and their associates of our three state medical schools, and other interested members, for the purpose of formulating a cooperative plan of a closer relationship and understanding between the North Carolina Psychiatric Association and other medical groups in our state. We found a most willing spirit to prevail among psychiatrists, and your chairman was instructed to formulate a letter to all doctors in the state in cooperation with Dr. A. B. Choate.

It was agreed at this conference that a series of lectures or seminars should be held two or three nights a week over a period of six weeks for the purpose of training family physicians and other interested doctors in a better understanding of psychiatry. The psychiatrists expressed a strong opinion that this would be the minimum amount of time that could be allotted for such a program if any real value was to be gained. However, upon making numerous inquiries among doctors from various parts of the state, I found that no adequate program could be successfully accomplished over a period of several weeks if doctors in the rural areas were required to obligate themselves to attend these meetings for two or three nights a week. This was not due to lack of interest but rather to lack of adequate spare time and the fact that no replacements were available to cover for them during their absence. This conclusion left us with the grave problem of what to do about the imminent crisis in the shortage of family physicians.

An extensive study has been undertaken by your committee and others during the

past year. Your chairman has met on several occasions with the deans of our three medical schools, the heads and chief consultants of the Duke Endowment Foundation, the president of our State Medical Society, and numerous others who are vitally interested in this matter.

Several letters of correspondence are enclosed, and much additional correspondence is available to those who are interested in this matter.

* * *

The foregoing statement was unanimously approved by the Board of Directors of the North Carolina Academy of General Practice. The remainder of the report represents the views of Dr. Ernest Furgurson, chairman of the Academy's Committee on Mental Hygiene.

As Americans, we have in the past 25 years come to desire and demand security, happiness, freedom, and authority. But the responsibility, which is an absolute prerequisite for these goals, has become an object to be shunned. We, as physicians, must prove our competence in this troubled world. We must assume the responsibility of leadership and guidance which our people expect of us, and this without delay. Need we be reminded that there are others far less competent who are striving for acceptance, leadership, and authority in the care of human ills?

There is today a widely approved trend in our society which has deeply infiltrated the applicants for internships. In earlier decades the house officer's life was primarily one of learning, and he responded to his patients' calls at all hours of the day or night. Today the intern has a temporarily limited duty to his patients, with a minimum time-off of alternate evenings after 5 o'clock and alternate week-ends. I quote from a letter dated March 9, 1960:

... the teaching hospitals, namely the Baptist Hospital, the Memorial Hospital at Chapel Hill, and Duke have entirely too many interns, residents, and fellows because they are lured by the research grants to spend entirely too long a period in the marble or ivory halls. For example, the Duke pediatric department did satisfactory work with one resident and six interns. Now pediatrics has three residents, six assistant resi-

dents, and fourteen interns. All of them seem to be busy on an eight-hour day and forty hour week instead of a sixteen hour day and seven days a week as in the old days—Dr. W. C. Davison.

What may we anticipate from this nationally accepted social tendency toward more unearned leisure? Will young doctors move en masse toward careers offering a 35 or 40 hour week? Will this lead to loud, numerous, and justified complaints about doctors who refuse to accept night calls and decline to accept patients on their days off? It certainly marks the rapid end to solo practice in rural areas, and this probably is as it should be. Many physicians who have entered solo family practice are returning to medical schools for research or specialty training as a matter of self-preservation. Easily available research grants are undoubtedly a motivating factor in this migration toward the inner sanctum of the ivory walls of security.

The potentially successful family physician will require early discovery, preferably at the high school level. He must be genuinely interested in his fellow man. He must love people. He will require careful intellectual nurture by highly trained teams and doctors who are willing to lay aside the formal lecture and communicate with him on a basis of straightforward information. There can be no sense of discouragement or cynicism. The family physician holds the key of communication with the present generation of high school and college students. He must transmit a sense of excitement, challenge, and personal fulfillment which will restore medicine to its justly deserved status.

Funds must be obtained immediately in sufficiently large amounts to compete with big business and the physical sciences. These funds should be solicited from private philanthropists, pharmaceutical companies, and other sources insofar as possible, as government participation would almost certainly lead to some degree of government control over our medical schools and professions. Outright grants should be allocated to medical students, interns, and residents.

A family physician or general practice section should be established in each medical

school. At present the student has no opportunity to choose, as he is exposed only to the specialists and the specialties. The gradual and careful development of a preceptorship program under the guidance of competent family physicians who would take students into their practices for periods of two to six weeks is of equal significance.

Solo practice in rural communities should not be encouraged. The heavy pressures and long working hours are a deterrent to self-preservation. Any community which can support one doctor can support two. Group practice of family physicians with clinic facilities allows free time on a rotating basis without sacrifice of medical services.

The major fields of training of family practice should be in internal medicine, pediatrics, psychiatry, and (to a lesser degree) obstetrics and gynecology.

Summary

The grave and basic problem facing North Carolina Academy of General Practice and the A.A.G.P. is the present and increasing shortage of family physicians. A discussion of this imminent crisis has been presented.

The following recommendations are submitted:

1. We must destroy the erroneous belief among students that it is impossible or extremely difficult to obtain a seat in a medical school.

2. Communication must be improved between medical schools, the medical profession, and student counselors. Participation of interested and qualified local physicians should be encouraged.

3. Outright grants sufficiently large to compete with big business and the physical sciences should be made available to those in medical training.

4. Philanthropic foundations, pharmaceutical houses, and other private groups should establish grants and loan funds. In addition, we should work for removal of state restrictions on medical students from other states.

5. A family physician or general practice section should be established in each medical school. A preceptorship program under supervision of competent family physicians

to take students into their practice is most significant.

6. We have evidence that several large philanthropic organizations are vitally interested in promoting this program. Their assistance should be actively and enthusiastically solicited.

In conclusion, our profession will continue to grow as long as the strong, the courageous, the unselfish, the competent, and the wise men assume the responsibility to guide the future of medicine in general, and specifically the challenges to potential doctors. We must offer such skillful guidance and leadership in a positive program such as I have outlined that the threat of failure in this noble and vital field will disappear and subsequent power by government or other pressure groups will become remote.

The basic problem is summarized in the following exchange of letters which appeared in the *Wall Street Journal* in October, 1960. Louis Kessel's letter is quoted in part.

Ernest W. Furgurson, M. D., Chairman

* * *

Editor, The Wall Street Journal:

Your editorial writer on the subject of medical care does not read your own news columns. Quoting from the September 14 issue: "A research organization puts the rise in the cost of medical care at 40% in the last five years." Again, "The Department of Commerce says medical care is now 6% of the public's total outlay for all its personal needs." This is represented as an increase from 4% over a short period. And you give news of more to come: "Blue Cross Wins 33.45% Rate Rise."

If the average family income is \$6,000 a year, the increase from 4% to 6% is an increase from \$240 to \$360, or \$120. This \$120 (\$2.40 per week) has been subtracted from what is available for food, clothing and consumer durables. No wonder consumers aren't buying cars or refrigerators . . .

If you complain (shame on you), you will be told about improved medical care or about the years the doctor spent in training. Anyone who has tried in vain to get a doctor to make a house call at night or on Wednesday (Doctor's day off) may not believe this claim about improved service. Anyway if the service were actually so good, there would be less sickness and less expense, rather than these increases. As to the years of training, did you ever hear a lawyer pull that one?

Louis Kessel

Chicago, Ill.

Editor, The Wall Street Journal:

The following facts are presented in reply to Mr. Louis Kessel's letter of September 26.

1. There is indeed a market shortage of medical care, namely, doctors who treat patients.

2. The quality and quantity of medical care is decreasing as a result of deflection of many physicians to fields of research and over-specialization.

3. The medical schools in our country are accepting over one out of every two persons who apply. Some schools are accepting almost every applicant. For example, in 1949-50 there were 24,434 applicants of whom 7,150 (21%) were accepted. This year there were only 14,951 applicants and 8,510 (56%) were accepted.

4. In 1951, 40% of all applicants were straight "A" students. Today only 16% are "A" students.

5. Electronics and nuclear physics today have more appeal than medical schools. These professions require less education (age 24 vs. age 30 before a doctor can begin to support his family), shorter working hours (40 hours per week vs. 70 to 80 hours for the general practitioner). There are economic factors (in-training grants of \$6,000 to \$9,000 per year vs. interns and residents whose incomes are equivalent to less than the lowest paid factory worker). This leaves the doctor heavily loaded with debt (\$12,000 average when he begins to practice at 30 years, even when the wife works to support the family and relatives chip in liberally during his training period).

6. Although many billions are appropriated by Congress each year for medical and health research, not one penny is appropriated to train doctors to treat patients. Thus our medical schools have become highly technical scientific training and research centers with most of their students becoming more interested in molecules than in human beings. But who will supply the physicians to apply these research findings?

As a country doctor who struggled through medical school during a depression some 25 years ago, I suggest the following remedies:

1. Whatever funds are necessary should be obtained immediately either from private philanthropic sources or from Congressional appropriation to train doctors to treat patients. These funds, in addition, should cover outright grants to medical students, interns, and residents, sufficiently large to compete with big business and the physical sciences.

2. The problem belongs to doctors and laymen alike. As Americans, let us stop goldbricking for a five-hour work day. If we are to have leisure, let us earn it. The pride and process of achievement upon which our country was founded is far more important than a loafer's holiday or the possession of goods.

E. W. Furgurson, M. D.

Plymouth, N. C.

Editor, The Wall Street Journal:

Regarding my letter of September 26 and the subsequent letters on medical care, I wish to apologize to the following:

1. Our family doctor. He is a conscientious dedicated doctor who deserves to be classed in the same category as the hero in the book "The Last Angry Man." My remarks were based on your articles and conversation with other people.

2. All other dedicated doctors. I am sorry my letter did not clearly separate them from the others.

As to the problem of high medical costs, the letters you printed on October 10 in reply to mine indicate a better knowledge of the subject than my own. In particular the remarks made by Dr. E. W. Furgurson cover points that everyone should know.

Louis Kessel

Chicago, Ill.

Bulletin Board

COMING MEETINGS

Forsyth County Cancer Symposium—Robert E. Lee Hotel, Winston-Salem, March 9.

Bowman Gray School of Medicine, Postgraduate Course in Obstetrics and Gynecology—Winston-Salem, March 21-23.

Community Health Conference on Mental Health, sponsored by the Committee on Rural Health and Education of the Medical Society of North Carolina—Wilson, March 22.

Duke University Medical Center, Refresher Course in Anesthesia—Durham, March 23-25.

American Cancer Society, National Cancer Congress—Hotel Sir Walter, Raleigh, Mar. 26.

North Carolina Society of Crippled Children and Adults, Eastern Regional Meeting; Seminar on Care of the Severely Disabled—East Carolina College, Greenville, March 16.

Greensboro Academy of Medicine, Annual Symposium—Greensboro, March 30.

Southeastern Psychiatric Association, Annual Meeting—Pine Needles Lodge, Southern Pines, April 3-5.

Medical Society of the the State of North Carolina, Annual Meeting—George Vanderbilt Hotel, Asheville, May 6-10.

American College of Allergists, Annual Congress—Statler-Hilton Hotel, Dallas, Texas, March 1-12.

Gill Memorial Eye, Ear and Throat Hospital, Spring Congress—Roanoke, Virginia, April 3-8.

American College of Physicians, Annual Session—Americana Hotel, Miami Beach, Florida, May 8-12.

American Medical Association, Annual Meeting—New York City, June 26-30.

NEW MEMBERS OF THE STATE SOCIETY

The following physicians joined the Medical Society of the State of North Carolina during the month of December, 1960:

Dr. Jesse Williams McCracken, 108 East Northwood, Greensboro; Dr. Curtis Ray Lashley, 110 S. Mendenhall Street, Greensboro; Dr. Fred Weston Glover, 309 Hawthorne Lane, Charlotte; Dr. Robert LeRoy Rollins, Jr., 831 West Morgan Street, Raleigh; Dr. Jacob Koomen, Jr., N. C. State Board of Health, Raleigh; Dr. Philip Jackson Fail, 1714 Westminster Drive, Columbia, South Carolina.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. Merrill P. Spencer, associate professor of physiology and pharmacology, has received a Senior Research Fellowship from the U. S. Public Health Service. The fellowship begins July 1, 1961. In providing for the investigator's support over a five-year period, the fellowship has an estimated value of more than \$75,000. Accompanying the fellowship is a \$7,500 supply grant which, like the fellowship, is renewable each year for five years. The fellowship will enable Dr. Spencer to continue work on a project aimed at the development of improved methods of evaluating heart performance.

Dr. Spencer is one of four members of the faculty here holding Senior Research Fellowships. Others are Drs. Harry M. Carpenter, assistant professor of pathology; Harold O. Goodman, assistant professor of medical genetics; and Samuel H. Love, assistant professor of microbiology and immunology.

On January 31, Dr. Spencer served as consultant to the cardiovascular study section of the National Heart Institute at a section meeting at Carmel, California. The section's primary concern was uses and applications of blood flowmeters.

* * *

Dr. Margaret C. Conrad has been named a research fellow of the American Heart Association for two years. The fellowship begins July 1, 1961. During the two-year period, Dr. Conrad will continue a study of peripheral and central pulses and peripheral blood flow and blood capacity in patients with vascular disease.

* * *

The Bowman Gray School of Medicine received \$145,350 in new research grants during December.

Receipts of the four grants, ranging in size from \$52,185 to \$14,200, was announced recently by Dr. C. C. Carpenter, dean of the medical school.

The funds will support investigations in the school's departments of anatomy, biochemistry, physiology and pharmacology, and radiology.

Of the four grants, two were made by the U. S. Public Health Service, one by the U. S. Atomic Energy Commission and one by the National Science Foundation.

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Dr. Ernest Yount, professor of internal medicine, has been elected chairman of the medicine committee of the National Board of Medical Examiners. He has been a member of the committee since June, 1958.

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Dr. R. Winston Roberts, professor of ophthalmology, was visiting professor of ophthalmology, December 15 and 16, at Baylor University School of Medicine. Dr. Roberts demonstrated the use and operations of instruments used in the mushroom corneal graft. This surgical technique and the instruments were developed in the department of ophthalmology at the medical school here. He also discussed clinical application of tests used to detect and treat glaucoma.

While in Texas, Dr. Roberts also spoke to the San Antonio Ophthalmologic Society on "Diagnosis and Handling of Early Glaucoma."

* * *

Dr. Wingate M. Johnson of the Department of Medicine, attended the White House Conference on Aging held in Washington January 9-13 as a delegate from North Carolina.

* * *

Dr. Joseph Whitley, instructor in radiology, presented a paper entitled "A Method and Parameters for the Analysis of Renal Function by External Scintillation Detector Techniques" before a recent meeting of the Radiological Society of North America at Cincinnati, Ohio. The paper was prepared by Dr. Whitley in collaboration with Drs. Isadore Meschan, professor and chairman of the department of radiology; radiology research assistant Richard Witcofski; and Dr. John H. Felts, assistant professor of internal medicine.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. Floyd W. Denny, Jr. has been named head of the Department of Pediatrics of the University of North Carolina School of Medicine.

He succeeds Dr. E. C. Curnen Jr., who recently accepted a similar position with Columbia University College of Physicians and Surgeons of New York City. The Columbia position is considered one of the highest in the field of pediatrics in the nation.

Dr. Curnen had been on the U.N.C. faculty since 1952, when the School of Medicine changed from a two-year to a full four-year program.

A native of Hartsville, South Carolina, Dr. Denny was educated at Wofford College and was awarded his M.D. degree by Vanderbilt University in 1946.

His internship and specialized training in pediatrics were received at the Vanderbilt University Hospital.

From 1948 to 1951 he was a research fellow in the Department of Preventive Medicine at Western Reserve University, being connected during this time with the Streptococcal Disease Laboratory of the Armed Forces Epidemiological Board. He was assistant director of the Laboratory during his final year.

Dr. Denny taught in the Department of Pediatrics of the University of Minnesota from 1951 to 1953. He then returned to the Vanderbilt School of Medicine for the next two years, where he was an assistant professor of pediatrics.

For the past five years, he has taught at the Western Reserve University School of Medicine in the Department of Pediatrics and the Department of Preventive Medicine.

* * *

The Bank of Chapel Hill has donated \$2,000 to the University of North Carolina School of Medicine to be used for scholarships during the next two years.

* * *

Six women graduated recently at North Carolina Memorial Hospital of the University of North Carolina after completing a 15-month course in x-ray technology. This is the thirteenth class in this speciality to graduate since the hospital first went into operation in 1952.

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Education personnel and public nurses throughout western North Carolina attended the Eye Health Workshop held recently at the School of Medicine of the University of North Carolina.

Public health nurses, school teachers, principals and school supervisors were taught how to screen school children for visual defects.

The Workshop was sponsored by the North Carolina Chapter of the National Society for the Prevention of Blindness.

* * *

Dr. John H. Ferguson, head of the Department of Physiology of the University of North Carolina, participated in a program for the dedication of the new Medical Research Building at the University of Alabama Medical Center in Birmingham on Friday, December 9. His talk on "Enzymes and Blood Coagulation" dealt with recent research at the U.N.C. School of Medicine. The research is in the field of blood coagulation and related problems and is supported by a grant from the U. S. Public Health Service.

* * *

Two postgraduate courses in medicine, sponsored by the University of North Carolina School of Medicine, are being conducted in Edenton and Kinston.

The courses consist of two lectures one day a week over a six-week period. The Edenton course is co-sponsored by the First District

Medical Society, and the Kinston course by the Lenoir-Green-Jones Medical Society.

All Edenton Lectures will be given in the Edenton Restaurant at 4:30 P.M. and 7:30 P.M. The Kinston lectures will be given in the Kinston Country Club at 4:30 P.M. and 8:00 P.M.

Both courses are acceptable for credit by the American Academy of General Practice for the number of hours attended by the individual physicians.

* * *

The U.N.C. Medical School sponsored four 30-minute weekly TV programs that followed the general theme, "A Report to the People from the School of Medicine." The series, which began Thursday, November 10, was seen on WUNC-TV at 9:30 for four consecutive Thursdays. The series presented for the public a picture of the activities of the Medical School and the North Carolina Memorial Hospital.

* * *

The University of North Carolina School of Medicine held its annual symposium Thursday and Friday, November 17 and 18. Some 70 physicians were present for the two day program on gastroenterology.

The guest participants on the program were Dr. Eddy D. Palmer, lieutenant colonel, Brooks General Hospital, Fort Sam Houston, Texas; Dr. Edward E. Owen, associate in medicine, and Dr. Malcolm P. Tyor, associate professor of medicine, both of Duke University School of Medicine, and Dr. David Cayer, clinical professor of medicine, Bowman Gray School of Medicine.

Participants on the program from the U.N.C. School of Medicine included: Dr. Charles A. Bream, associate professor of radiology; Dr. Tilhamer Z. Csaky, professor of pharmacology; Dr. Fitzgerald Hiestand, Jr., fellow in medicine; Dr. Jacqueline C. Hijmans, instructor in medicine; Dr. Walter Hollander, Jr., assistant professor of medicine.

Dr. Oscar L. Sapp, III, instructor in medicine; Dr. John T. Sessions, Jr., associate professor of medicine; Dr. George K. Summer, assistant professor of pediatrics; Dr. Colin G. Thomas, Jr., associate professor of surgery; Dr. Nathan A. Womack, professor of surgery and Dr. W. Geoffrey Wysor, Jr., instructor in medicine.

NEWS NOTES FROM THE DUKE UNIVERSITY SCHOOL OF MEDICINE

A \$75,000 expansion and renovation of urology facilities has been completed at the Duke University Medical Center.

Doubling the size of Duke Hospital's urology clinic, the eight-month project has made possible more rapid service to patients and a greater degree of individual attention and privacy, according to Dr. Edwin P. Alyea, professor of urology.

* * *

A distinguished Duke University scientist was named president-elect of the American Association for the Advancement of Science in New York last month.

Dr. Paul Gross, William Howell Pegram Professor of Chemistry, will take office on January 15, 1962 (CQ) for a one-year term. He will succeed 1961 president Thomas Park of the University of Chicago.

Dr. Gross has been president of the Oak Ridge Institute of Nuclear Studies since 1949 and member of the Institute's Board of Directors for the past five years. During 1952-53, he was president of the Council of Southern Universities.

A Duke faculty member since 1919, he has served as chairman of the chemistry department dean of the Graduate School of Arts and Sciences, dean of the University and vice-president in the University's Division of Education.

* * *

A new organization has been established to further the growth of one of the Nation's outstanding medical history collections at Duke University, it was announced recently by Deaf Barnes Woodhall of the Duke School of Medicine.

Known as the Associates of the Trent Collection in the History of Medicine, the organization is composed of Duke Medical School alumni, faculty members and friends of the University. Dr. George J. D'Angelo of Erie, Pennsylvania, a former Duke surgeon, is chairman of the Associates.

The Trent Collection was assembled between 1938-48 by the late Dr. Josiah C. Trent of the Duke surgical faculty and his wife, now Mrs. James Semans of Durham. In 1956, Mrs. Semans gave a portion of the collection to the Duke Medical Center Library, and two years later, the remaining materials were transferred to Duke.

Dr. D'Angelo said that all persons interested in the history of medicine are invited to join the Associates of the Trent Collection. Information can be obtained by writing Miss Judith Farrar, Duke University Medical Center librarian.

* * *

Dr. Ewald W. Busse and Dr. Arthur Larson of the Duke faculty delivered two of the major addresses heard at the White House Conference on Aging held in Washington January 9-13. Dr. Busse, director of Duke University's Center for the Study of Aging, is chairman of the White House Conference Committee on Medical Research in Gerontology.

* * *

Can toxemia of pregnancy, a leading cause of mothers dying in childbirth, be prevented by special diets? A Duke University Medical Center obstetrician, Dr. Walter B. Cherny, is looking for the answer to this question through studies of a body-manufactured chemical serotonin.

Supported financially by the National Institutes of Health, principal research arm of the U. S. Public Health Service, Dr. Cherny's re-

search is aimed specifically at finding out whether or not serotonin is linked with toxemia of pregnancy.

* * *

Dr. J. M. Arena, director of the Duke Hospital Poison Control Center, collects bottle caps.

Dr. Arena's interest in bottle caps is that of a pediatrician concerned with saving the lives of children. Through his efforts safety caps have been adopted by two major aspirin manufacturers and are being considered for other products. His goal is to help protect children from poisoning by way of the family medicine cabinet.

* * *

Duke University medical student William B. Waddell, president of the Student American Medical Association, was a delegate to the White House Conference on Aging, January 9-13.

In a statement of the Association's views on medical care for the aging, he charged that political maneuvering has entered into this area of growing concern. He also cited a SAMA resolution stating that any program of medical care for aged should provide for free choice of physicians and individualized patient care in a situation that provides the best condition for the practice of medicine.

FORSYTH COUNTY CANCER SYMPOSIUM

The tenth annual Cancer Symposium sponsored by the Forsyth County Medical Society will be held at the Robert E. Hotel in Winston-Salem, March 9.

The program of the symposium is entitled "Newer Methods of Cancer Diagnosis." Speakers will be Drs. George E. Moore, Roswell Park Memorial Institute, and Buffalo, New York; Cyrus C. Erickson, University of Tennessee, Memphis; Stuart W. Lippincott, Brookhaven National Laboratory, Upton, New York.

Dr. James Harrill, president of the Forsyth County Society, will preside at the dinner session at 7:00 p.m., at which Dr. Lippincott will speak on the subject, "What the Atom is Doing for You."

NORTH CAROLINA COUNCIL ON FOODS AND NUTRITION

The North Carolina Council on Foods and Nutrition held an organizational meeting in Raleigh on October 18, 1960. Attending were 23 representatives of organizations or agencies interested in promoting better nutrition among North Carolinians.

A constitution and by-laws were accepted with recommended changes, subject to the approval of the executive committee. Dr. Naomi Albanese was elected president of the new organization.

FORSYTH COUNTY MEDICAL SOCIETY

The Forsyth County Medical Society held its regular monthly meeting at the Robert E. Lee Hotel in Winston-Salem on January 10. The program consisted of a panel discussion on counseling. Speakers and their subjects were: Dr. Dan Moffie, Hanes Hosiery Mills—"Counseling in Industry"; Dr. Richard Young, North Carolina Baptist Hospital—"Pastoral Counseling"; and Dr. Richard C. Proctor, Bowman Gray School of Medicine—"Counseling vs. Psychotherapy."

NATIONAL MEDICAL FOUNDATION FOR EYE CARE

A greatly expanded informational program on the meaning and value of good eye care is planned for 1961 by the National Medical Foundation for Eye Care. The Foundation was organized in 1956 as a public educational agency for American ophthalmology, and most of its 3,000 members are Diplomates of the American Board of Ophthalmology.

The Foundation's Board of Trustees, at its recent annual meeting, re-elected Dr. Ralph O. Rychener of Memphis as president for a fifth term. Dr. Harold F. Falls of Ann Arbor, Michigan, was elected chairman of the Executive Committee. Other officers include Dr. Barnet R. Sakler of Cincinnati, vice-president, and Dr. Charles E. Jaekle of Defiance, Ohio, secretary and treasurer.

AMERICAN SOCIETY OF PSYCHOSOMATIC DENTISTRY AND MEDICINE

The annual meeting of the American Society of Psychosomatic Dentistry and Medicine will be held at the Shoreham Hotel, Washington, D. C., March 10-12.

The main theme of the program will be "Anxiety: Its Recognition and Handling in the Clinical Setting of General Practice." During the meeting round table discussions will be held on "The Utilization of Hypnosis in the Various Specialties of General Practice." All dentists and physicians are cordially invited to attend.

For details, address Dr. Jesse Caden, Chairman, Program Committee, 5213 Connecticut Avenue, N.W., Washington 15, D. C.

AMERICAN COLLEGE OF ALLERGISTS

The American College of Allergists holds its graduate instructional course and seventeenth Annual Congress, March 12-17, 1961, at the Statler Hilton, Dallas, Texas. For information write, John D. Gillespie, M. D., Treasurer, 2141 14th Street, Boulder, Colorado.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The American Board of Obstetrics and Gynecology announces that the next scheduled examinations (Part II), oral and clinical, for all candidates, will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from April 8 through 15, 1961. Formal notice of the exact time of each candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part I examination will be notified of their eligibility for the Part II examinations as soon as possible.

Current Bulletins of the American Board of Obstetrics and Gynecology outlining the requirements for application, may be obtained by writing to the Secretary: Robert L. Faulkner, M.D., 2105 Adelbert Road, Cleveland 6, Ohio.

AMERICAN COLLEGE OF SURGEONS

The fifth Postgraduate course on Fractures and Other Trauma sponsored by the Chicago Committee on Trauma of the American College of Surgeons will be held April 15-22, at the John B. Murphy Memorial Auditorium, 50 East Erie Street, Chicago.

Dr. Sam W. Banks, Chairman of the Chicago Committee on Trauma, is Director of the Course. Inquiries should be addressed to Dr. John J. Fabey, who is Chairman of the Committee on the Post-Graduate Course on Fractures and Other Trauma.

NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

More than 1,847,000 persons enrolled in the 74 Blue Shield Plans located in North America during the first nine months of 1960, and during the same period the Plans paid out approximately \$550,000,000 for care rendered to members, the National Association of Blue Shield Plans announced recently.

"Of special significance is the fact that the \$550,000,000 paid to physicians was an all-time high in payments for a nine month period, and represented approximately 91 per cent of the total income of all Blue Shield Plans," the national association indicated in its report. At the same time, the 74 Blue Shield Plans were reported to have expended less than 10 per cent of total income for administrative expenses.

"The preference for Blue Shield on the part of Federal Employees and the public at large," the national association concluded, "reflects the general acceptance of the programs offered by Blue Shield Plans across the country. At the same time, the record payments to physicians during the nine-month period points up the extent to which these Plans help members pay for medical care."

DEPARTMENT OF THE ARMY

Many of the medical lessons learned during World War I had to be relearned during World War II because of paucity of distribution of the World War I medical history.

Lieutenant General Leonard D. Heaton, The Army Surgeon General, in an endeavor to prevent this costly relearning process, in the unhappy event of another war, has directed the preparation, publication, and distribution of the "History of the Medical Department, United States Army, in World War II." General Heaton is particularly anxious that information of the existence and availability of this history be circulated widely among the profession, both military and civilian.

Of the 48 volumes programmed for the series, 15 have been published and can be purchased at modest cost from The Superintendent of Documents, Government Printing Office, Washington 25, D. C. The set of 15 volumes may be purchased for \$66.50, or individual volumes can be obtained at remarkably low prices. Commanding officers of medical units may requisition copies for their Medical Units libraries by submitting DA Form 17 directly to The Historical Unit, U. S. Army Medical Service, Washington 12, D. C., ATTN Promotion Branch.

Volumes now available are:

General Surgery—Edited by Michael E. DeBakey
Neurosurgery, Volume I (Head Injuries)—Edited by R. Glen Spurling, M.D. and Barnes Woodhall, M.D.

Neurosurgery, Volume II (Spinal Cord and Peripheral Nerve Injuries)—Edited by R. Glen Spurling, M.D. and Barnes Woodhall, M.D.

Hand Surgery—Edited by Sterling Bunnell, M.D.

Ophthalmology and Otolaryngology—Edited by M. Elliott Randolph, M.D. and Norton Canfield, M.D.

Orthopedic Surgery, European Theater of Operations—Edited by Mather Cleveland, M.D.

Orthopedic Surgery, Mediterranean Theater of Operations—By Oscar P. Hampton, M. D.

Physiologic Effects of Wounds—Edited by Fred W. Rankin, M.D. and Michael E. DeBakey, M.D.

Vascular Surgery—Edited by Daniel C. Elkin, M.D. and Michael E. DeBakey, M.D.

Cold Injury, Ground Type—By Tom F. Whayne and Michael E. DeBakey, M.D.

Dental Service—George F. Jeffcott, D.M.D.

Environmental Hygiene—By James Stevens Simons, M.D. and others

Personal Health Measures and Immunization—By John E. Gordon, M.D., Tom F. Whayne, M.D. and others

Communicable Diseases, Vol. IV—By John E. Gordon, M.D., Joseph Stokes, M.D. and others

Hospitalization and Evacuation, Zone of Interior—By Clarence McKittrick Smith

VETERAN ADMINISTRATION

Veterans Administration hospitals have begun a largescale evaluation of six drugs used in the treatment of mental illness.

More than 500 schizophrenic patients newly admitted to 36 hospitals will be involved in the 24-week, controlled study.

The project is designed to yield information on the relative effectiveness and suitability of the drugs for patients of this sort, so as to enable doctors to improve treatment for schizophrenia.

The drugs under evaluation in the new study (chlorpromazine, fluphenazine, reserpine, thioridazine, chlorprothixene, and trifluorpromazine) are representative of a wide spectrum of the various psychopharmacologic agents.

Among the 36 participating VA hospitals is the one at Durham.

* * *

Dr. James H. Matthews, assistant chief of pulmonary disease service at the Oteen, Veterans Administration hospital, has been appointed chief of the Veterans Administration's clinical research in pulmonary diseases. He also will coordinate the large-scale VA—Armed Forces cooperative studies in pulmonary diseases.

Dr. Matthews assumed his new position at the VA Central Office in Washington, D. C., January 8. He joined the VA at the Oteen hospital in February, 1946.

* * *

An atomic medical technique that readily reveals abnormalities in brain blood flow that may lead to brain damage from strokes has been developed by Dr. W. H. Oldendorf, neurologist of the Veterans Administration Center in Los Angeles, California.

The technique also is useful for more readily diagnosing other abnormalities of the blood vessels of the brain.

The procedure tracks the blood flow and distribution in the brain. It causes the patient no discomfort except the slight pain of the point of an injection with a small needle.

A small amount of radioactive iodine (I-131) is injected into an arm vein.

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

Dr. Howard B. Andervont, a member of the original research staff of the National Cancer Institute and a former president of the American Association for Cancer Research, has relinquished his duties as Chief of the Institute's Laboratory of Biology.

Although eligible for retirement, Dr. Andervont will continue his research in the laboratory he supervised for 15 years. He has also been appointed scientific editor of the *Journal of the National Cancer Institute* by Dr. Kenneth M. Endicott, Institute Director. In this capacity he

succeeds Dr. Michael B. Shimkin, who was recently named Associate Director for Field Studies.

Through research in chemical carcinogenesis, Dr. Andervont showed that the nature and duration of carcinogenic stimuli influence the biological properties of cancer. In studies of the role of hormones in the development of cancer, he demonstrated that some tumors may progress from hormone-dependence to autonomy.

In commenting on Dr. Andervont's achievements, Dr. Endicott described him as 'a scientist of exceptional talents and unstinting devotion, whose visionary leadership has sparked much of the intensive research now being conducted. It is fortunate for the Institute and for the scientific community that Dr. Andervont will continue to make available the keen judgment and brilliant insight that have marked his long and productive career.'

Dr. Heston has been a member of the Institute staff since 1938 and since 1952 has headed the General Biology Section of the Laboratory of Biology. His research has been concerned primarily with the genetics of cancer. He is a former scientific editor of the *Journal of the National Cancer Institute*.

* * *

The assignment of a Public Health Service career officer, Dr. John C. Cutler, to serve as assistant director with the Pan American Sanitary Bureau, was announced recently by Surgeon General Leroy E. Burney.

Dr. Cutler's new assignment was made at the request of Dr. Abraham Horwitz, director of the Pan American Sanitary Bureau. This Bureau serves as the operating arm of the Pan American Health Organization and also as the World Health Organization's regional office for the Americas.

Average life expectancy in this country has increased by more than 22 years during the present century, Health Information Foundation reports. The average baby born in 1900 could expect to live only 47.3 years, against 69.7 years for one born in 1959.



The Month in Washington

Spokesmen for the medical profession at the White House Conference on Aging supported the Kerr-Mills voluntary program for health care of elderly persons as an efficient, economical way to furnish assistance to those who need help.

Leading medical delegates to the conference also continued vigorous opposition to the Social Security approach espoused by organized labor.

Continuing their all-out campaign for the Social Security approach, labor union leaders used the Conference as a forum for further attacks on the medical profession.

Dr. J. Lafe Ludwig of Los Angeles, chairman of the American Medical Association Council on Medical Service told a pre-conference meeting of the physician delegates that it would be a "national tragedy—unfair to old and young alike—if the Kerr-Mills law should be shelved for a Social Security plan for medical care of the aged.

"Federal medicine would mean red tape, bureaucratic control, and high costs," Dr. Ludwig said. "Most important of all, it would mean inferior medical care for the people whom we are

From the Washington Office of the American Medical Association.

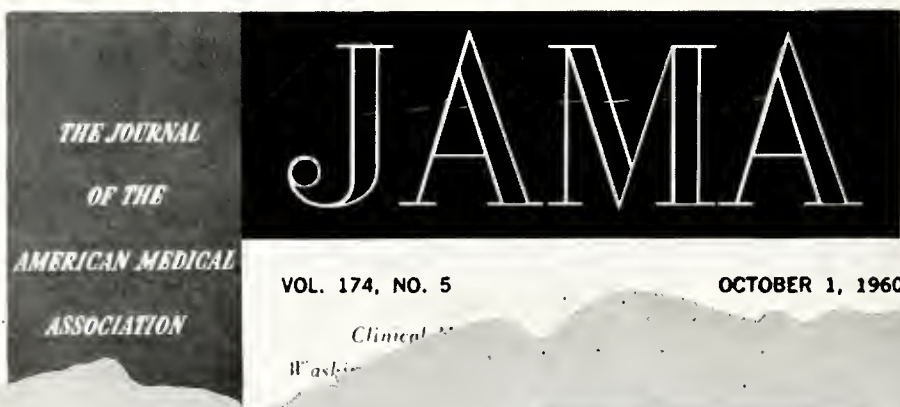
trying to help."

Dr. Leonard W. Larson of Bismarck, North Dakota, president-elect of the A.M.A., told the Health and Medical Care Section of the conference that more attention must be given to keeping older persons healthy. He was chairman of the section.

"We spend millions of dollars and hours developing sound, well-based programs for care of the sick, but at the same time we virtually ignore the vast opportunities for preservation and promotion of health," Dr. Larson said. We must do more than react to the minority of older persons who are ill—we must act for the great majority who are well."

In a statement issued in Chicago, Dr. E. Vincent Askey of Los Angeles, President of the A.M.A., branded as false an allegation that the White House Conference had been "captured" by organized medicine, private insurance, and business interests. Dr. Askey specifically referred to such a charge made by Prof. Wilbur J. Cohen of the University of Michigan, but the A.M.A. president's statement applied to similar charges made by representatives of organized labor.

Dr. Ludwig also answered organized labor's attacks on the A.M.A. at the conference. Dr. Ludwig accused George Meany, president of the AFLCIO, of "attempting to undermine" the Con-



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ference to "further his own partisan interests."

"Of the 30 states making specific recommendations regarding financing of medical care for the aged, only 10 favored the Social Security tax," Dr. Ludwig said.

President Eisenhower urged the 2,700 delegates to the conference to reconcile their differing views and agree on a sound program. He told the delegates it was their responsibility to provide "some kind of guidance for Congress to use in its future deliberations."

President John F. Kennedy declined an invitation to address the conference as President-elect. He and Congressional Democratic leaders decided weeks before the conference to make medical care for the aged under Social Security an Administration priority bill for early submission to Congress.

But some key Democrats in Congress announced they would not go along with President Kennedy on the issue. Senator Robert S. Kerr (D., Okla.), co-author of the medical-care-for-the-aged program approved by Congress last year, said it should be financed by a general tax—"not a limited tax like Social Security."

Similar opposition to the Social Security approach was expressed by Senator John J. Sparkman (D., Ala.). Chairman Harry F. Byrd (D., Va.) of the Senate Finance Committee earlier had said he was convinced that providing medical care for the aged under Social Security would lead to socialized medicine and possibly bankrupt the Social Security trust fund.

Despite the Kennedy Administration's espousal of the Social Security plan, the A.M.A. pledged its continued cooperation to the Department of Health, Education and Welfare on other health programs.

A group of A.M.A. officials headed by Dr. Askey told the new H.E.W. secretary, former Gov. Abraham Ribicoff of Connecticut, at a pre-inaugural conference that the Association "pledges its continued cooperation to H.E.W. to work for the best medical care for the nation." The A.M.A. "has always had a deep sense of responsibility for the health needs of the people," Dr. Askey said.

The A.M.A. officials also advised Ribicoff that they would help implement the Kerr-Mills Act in any way possible.

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1. Barclay, P. L.: J.A.M.A. 174:474, Oct. 1, 1960.

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Book Review

French's Index of Differential Diagnosis.

Edited by A. H. Douthwaite. 1,111 pages. Price, \$21.00. Baltimore: The Williams & Wilkins Company, exclusive U. S. agents, 1960.

This eighth edition, the first to appear since 1954, is a most thorough and accurate guide to differential diagnosis. The contents are arranged alphabetically according to the signs and symptoms, and the lists and the number of signs and symptoms covered is most complete. Individual articles are well written and thorough. The use of British terminology and spelling does not lead to any serious confusion. The illustrations are well chosen and clear, and several color plates are used where necessary to show a lesion to best advantage. The index comprises some 150 pages and, as far as this reviewer could determine, is complete, accurate, and easy to use. The authorities who have written various sections are well informed, and write with the usual British clarity and simplicity.

All in all, this is a most valuable book to anyone who is concerned with differential diagnosis, and should find a place in the library of almost any practicing physician.

In Memoriam

William Bryce Hunt, M.D.

William Bryce Hunt died suddenly in Duke Hospital on May 18, 1960. He was born in Davidson County on November 23, 1895, and was graduated from the old Churchland Boarding School. He attended Wake Forest College, and was graduated from the University of Maryland in 1923. Shortly afterwards he came to Lexington to become associated with Dr. J. A. Smith in the practice of medicine. This partnership continued until Dr. Smith opened the old Davidson Hospital and moved his office to this building.

Dr. Hunt had three consuming interests—medicine, politics, and real estate—and in each field he was a master. That he was a good doctor is attested by his patients and his colleagues. In politics his judgment was sought in every election, whether local or national. He served his city in the capacity of mayor for several terms, and at the time of his death, had entered the hospital to find whether his state of health would warrant a political battle for the State Senate. In the field of real estate, he started many of the residential extensions of the city and gave the land on which the present Municipal Golf Course

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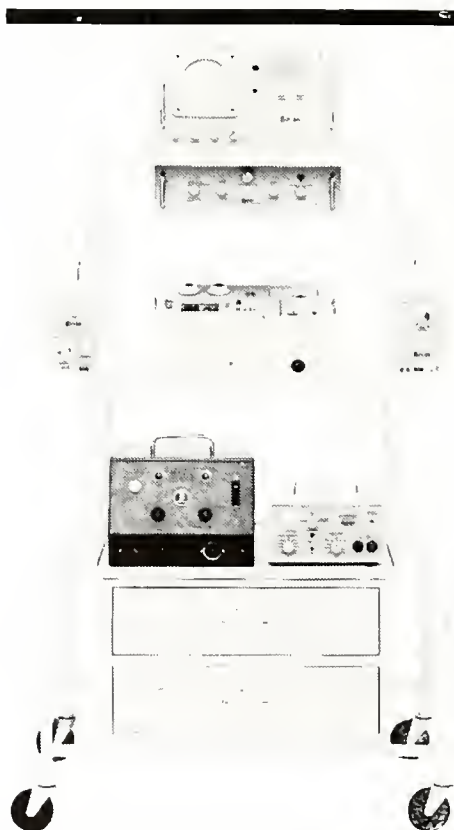
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is built. He was a director of one of the local Building and Loan Associations.

Dr. Hunt was outspoken, and never failed to formulate or state an opinion on any controversial issue. His friends all loved him and his foes respected him. He will be missed by both alike.

David Edwin Plummer, M.D.
1908-1960

David Edwin Plummer was born on June 30, 1908, in Randolph County, North Carolina, to Kearney Philmore Plummer and Lula Alice Heppler. He attended public schools in Randolph County and Rutherford College in Rutherfordton. His pre-medical work was done at Duke University, and he graduated from the Medical College of Virginia in 1936. He had internship and residency training in Denver, Colorado.

Dr. Plummer served in the Army Medical Corps for five years, and was discharged with the rank of Colonel. Eighteen months of his time was served in the China-Burma-India theater of operations.

Fourteen years of Dr. Plummer's practice of medicine was in Thomasville, North Carolina. During this time he served a term as county coroner and was active in county and city affairs of various kinds. He practiced medicine for one year in Durham, and for two years in Denton, during his earlier years of practice.

Dr. Plummer died at the Veteran's Hospital in Durham, on May 13, 1960, following an illness of approximately three years and a critical illness of about three weeks. He is survived by his wife, the former Edith Pittman, two sons, David and Joseph Edward, and a daughter, Peggy Anne.

Dr. Plummer will long be remembered in this area for his devotion to the art and science of medicine and for the selfless way in which he gave of his very life and means to those who sought his help.

William Wake Shelton, Jr., M.D.
November 15, 1927 — October 21, 1960

William Wake Shelton, Jr. was born November 15, 1927 in Kinston, North Carolina. He grew up in that city, and was graduated from Grainger High School in 1945, receiving the Curtis Cup, awarded to the outstanding student in the graduating class of that school.

Bill Shelton attended North Carolina State College in 1945 and 1946, and in this latter year volunteered for military service. He was attached to the Alaskan Service Base Engineers from which post he was discharged in 1948.

Following military service, he attended Wake Forest College, where he was elected to Phi Beta Kappa as well as to social and professional fraternities. He was graduated **Summa Cum Laude** in 1951, and in 1955, received his M.D. Degree from the Bowman Gray School of

Medicine. Graduate training in internal medicine followed at the North Carolina Baptist Hospital until 1959, at which time, he was Chief Resident Physician.

On July 6, 1959, Dr. Shelton began the practice of internal medicine in Henderson, North Carolina, where he was on the staffs of the Maria Parham and Jubilee Hospitals. He resigned these affiliations in July, 1960, due to illness and returned to Winston-Salem as physician for Wake Forest College and instructor at the Bowman Gray School of Medicine. These posts were held until illness prevented the performance of necessary duties, and on October 21, 1960, he died as a result of leukemia at the North Carolina Baptist Hospital, leaving his wife, the former Helen Hall of Oxford, and two children, Julia Horner Shelton and William Wake Shelton, III.

The Vance County Medical Society duly recognized the great loss sustained by the medical profession and the community in the passing of its beloved colleague.

It is, therefore, resolved that the foregoing be added to the minutes of the meetings of the Vance County Medical Society and to the proceedings of the staff of the Maria Parham Hospital and that a copy of this resolution be sent to Mrs. Helen Shelton.

Vance County Medical Society and
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NORTH CAROLINA

Medical Journal



March, 1961
Vol. 22 No. 3

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Annular Pancreas in the Adult: Report of Four Cases

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This paper will describe briefly, and illustrate, the principal clinical and roentgenographic findings of four surgically verified cases of annular pancreas in adults. In each case, the primary roentgen diagnosis was made preoperatively.

Annular pancreas, first described by Tiedemann in 1818 and named by Ecker in 1862¹, was once thought to be a very rare congenital anomaly, but it has been reported with increasing frequency in the past 10 years. Between 125 and 150 cases have been described to date in the world literature. Approximately one third of these were found in infants and young children². A total of about 110 cases, including the pediatric ones, have been treated surgically³. Of approximately 74 adult cases, only 23 per cent were correctly diagnosed before operation¹.

Embryology and Anatomy

The most likely explanation of annular pancreas is persistence of the left half of the ventral pancreatic anlage, which ordinarily atrophies. The resulting tissue grows around the duodenum to join the dorsal pancreas, so that the duodenum is encircled by pancreatic tissue⁴. Failure of the ventral anlage to rotate to the right and posteriorly with the duodenum may also play a part in the process⁵.

Whatever the actual process, the resulting ring-like structure is made up of normal pancreatic tissue, including a duct system. This system loops around the duodenum

posteriorly to empty into the duct of Wirsung. The annulus is not complete in all cases, and if incomplete, the gap is usually found anteriorly. A fibrous band may join the two ends⁵.

The region of encirclement is the descending or second part of the duodenum in most cases. However, the other parts of the duodenum can also be involved⁵. Inclusion of the ampulla of Vater in the ring is uncommon, particularly in adults. When this does occur, jaundice is a prominent and early feature, leading to discovery of the condition in young infants⁴.

Pathology

The one most important result of the annulus, and causing most of the symptoms, is duodenal obstruction of varying degrees¹. This frequently produces a secondary dilatation of the duodenum proximal to the lesion. The stomach may also become dilated.

Three basic clinical types of annular pancreas are recognized, depending upon the amount of obstruction produced: (1) complete or almost complete, requiring surgery shortly after birth; (2) partial, occurring in later life; (3) minimal or none, in which case the lesion is not found except at the autopsy table¹.

Other diseases of the upper gastrointestinal tract act as trigger mechanisms to produce symptoms in the second type³. One such condition is acute or chronic pancreatitis of the annulus or pancreas proper. Pancreatitis has a high incidence of association with annular pancreas in the adult¹.

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Associated carcinoma in either the annulus or pancreas itself is rare¹.

Another condition frequently associated with annular pancreas is peptic ulcer, or at least inflammation of the duodenum or stomach⁶. Duodenal ulceration usually occurs proximal to the annulus. Only 2 cases have been reported in which ulcer was found in the constricted portion of the duodenum. One of these is described in this paper (case 1, fig. 2).

Gallbladder disease associated with annular pancreas has been reported, but it is not common⁷.

Incidence

One of the most interesting facts concerning this anomaly is that many more cases in adults than in infants have been reported¹. In the past few years however, a higher percentage of cases in infants has been found. Basically, the obstruction seems to be more potential than actual in a majority of cases.

In the adult group, ages have ranged from 17 to 81 years. The latter patient (case 1 in this report) is the oldest recorded in the literature.

Annular pancreas occurs much more frequently in males than females⁶. There is no racial predilection.

Symptoms

The symptoms are mainly due to the degree of duodenal obstruction⁵. They may be severe and of sudden onset, or chronic and mild.

Chief complaints have been pain, usually epigastric, and vomiting. Pain occurred in 90 per cent of the cases reviewed by Drey¹, and varied from a sense of bloating to a cramping, intermittent type, somewhat similar to that associated with acute peptic ulcer.

Vomiting occurred in almost two thirds of Drey's cases¹. Hematemesis was rare. Nocturnal aggravation of pain and vomiting were thought to be important diagnostic findings. Another observation was the presence of a generally good nutritional state, maintained in spite of a usually long duration of symptoms. The frequent presence of pancreatitis or peptic ulcer



Fig. 1. (Case 1) The duodenal loop ring-like defect is well demonstrated on this film made in 1952. Here the annulus completely surrounds the loop.

further complicates the clinical picture.

Laboratory studies are not helpful in diagnosing this condition⁸.

Roentgen Criteria

In adults, roentgen examination of the upper gastrointestinal tract with contrast medium is the only clinical method of making a diagnosis⁵. The bulb and the duodenum proximal to the annulus show varying degrees of symmetrical dilatation. In uncomplicated cases, no spasm of the duodenum is present. The characteristic smooth, eccentric, or ring-like deformity of the duodenum caused by the annulus is visualized as a constant defect on all films. The defect and caliber of the lumen are unchanged by the patient's posture, respiratory phase, straining, stage of digestion, or by any external pressure⁹. There is no tenderness or mucosal destruction. The mucosal folds may be smaller than normal. On repeated studies, no matter how many nor how far apart, the deformity always has the same appearance⁹. This is demonstrated in case 1, figures 1 and 2.

The defect itself may be a ring-like constriction, if the annulus is large and complete; but usually it is a smooth, rounded pressure defect found on the outer border of the duodenal loop, measuring 1 to 3 cm. in length. This produces an eccentric narrowing of the duodenal lumen^{5,9}.



Fig. 2. (Case 1) In 1955, when this study was made, the defect was exactly the same as in 1952. At this time, an acute ulcer was found in the constricted portion of the duodenum. It can be partly seen on the anterior (greater curvature) border of the defect. Note dilatation of the cap.

The roentgen diagnosis of annular pancreas in the infant is quite different from that in adult and will not be considered here.

Differential Diagnosis

Postbulbar ulcer and neoplasms of the duodenum or surrounding structures are important considerations in the differential diagnosis of annular pancreas⁹. This is particularly true of benign duodenal ulcers, since they often occur with annular pancreas. One of these conditions could easily mask the other, as in case 1.

Ulcers of the postbulbar area show thickening and irregularity of the mucosal pattern, irritability of the duodenum, and usually the presence of a crater⁹. Duodenal neoplasm shows irregularity and destruction of the mucosa. It is a rare condition.

Pancreatic neoplasm may pose a difficult differential problem. However, the pressure defect often extends into the inner border of the loop, with more irregularity and effacement of mucosal folds. Also, the retrogastric space may be increased on upright lateral films.

The large duodenal bulb frequently associated with annular pancreas indicates a benign, long-standing obstruction which is usually not seen in the other lesions⁹.

A few other conditions should be mentioned in the differential diagnosis, but the majority are rare and the differential diagnosis is not too difficult in most cases. Some of these are cholecystoduodenocolic bands, aberrant vessels, aberrant tissue rests, diverticula, and inflammatory adhesions⁸.

Treatment

For the adult symptomatic patient the only treatment is surgery. Originally, the annulus itself was resected, but this procedure proved to be unsatisfactory. Not only were there many complications, including pancreatitis and fistula formation, but also the relief of symptoms was inadequate. Various by-passing procedures and other operations were tried. From these experiences the consensus of surgeons at present is that a gastrojejunostomy of some type will give the most satisfactory results^{4,8,10}.

Three of our patients (cases 1, 2, and 4) were treated by gastrojejunostomy, and the other (cases 3) by gastroduodenostomy. Recent follow-ups have shown that all have had satisfactory relief of symptoms. In other cases, however, results have not always been entirely successful, and varying degrees of symptoms have persisted.

Illustrative Cases

Case 1

An 81 year old diabetic white male was first examined by us in 1950, when he complained of epigastric pain after meals. X-ray examination showed an area of postbulbar duodenal constriction, thought to be spasm and scarring from a healed ulcer. Annular pancreas was considered. In 1952 he was re-examined after an upper gastrointestinal hemorrhage with hematemesis. Roentgenograms showed persistence of the duodenal defect. In 1955 persisting epigastric pain resulted



Fig. 3. (Case 2) These "spot" films show a fairly typical pressure defect of the duodenal loop from annular pancreas. The deformity persists on all films. The cap is slightly dilated.

in another x-ray study which showed the duodenal constriction and a 7-mm. ulceration at the site. While he was being treated for the duodenal ulcer, a partial duodenal obstruction developed. On repeat radiologic examination, the deformity was seen without evidence of active ulcer. This examiner also suspected annular pancreas. Surgery was deferred because of advanced age and diabetes mellitus.

In 1958 the patient ate a frankfurter and immediately began to have epigastric pain with hematemesis. A gastrointestinal series again showed the same duodenal defect, and the primary impression was annular pancreas.

Operation confirmed the diagnosis of annular pancreas.

He has made an excellent postoperative recovery and now supervises his farm. In retrospect, he recalls epigastric pain of 65 years' duration.

Case 2

This 49 year old white man was examined in 1956 for anxiety state. At that time his appetite was good.

In 1958 he was again examined for a similar complaint, but within the preceding year anorexia and frequent nausea had developed. The nausea occurred one or two hours after eating, lasted an hour, and then disappeared without pain. In spite of these complaints he gained 8 pounds between the two examinations. A gastrointestinal series showed a defect in the second part of the duodenum with partial obstruction.



Fig. 4. (Case 3) Typical appearance of annular pancreas constricting the second part of the duodenum.

This was interpreted as annular pancreas. Roentgenograms taken in 1955 in another hospital were reviewed and showed the same defect.

An operation done on February 14, 1958, confirmed this diagnosis, and an anterior gastrojejunostomy was performed. The last follow-up examination in 1959 disclosed an incisional hernia and anxiety state, but digestive function was adequate.

Case 3

This 31 year old white man was examined in 1957 on admission to the hospital after an episode of syncope. He gave an incidental history of epigastric and right mid-abdominal pain occurring after meals for at least two years. An appendectomy had been performed during an attack of pain, but did not bring relief. An isolated episode of hematemesis occurred three months prior to our examination. A gastrointestinal roentgenogram made at that time was reportedly negative.

Our physical examination was that of a normal male. A roentgenogram of the upper gastrointestinal tract showed an extrinsic lesion in the second part of the duodenum, which was diagnosed as annular pancreas. Operation confirmed his diagnosis, and a gastroduodenostomy was performed.

The last follow-up examination in 1959 revealed severe psychiatric difficulty but no known digestive complaints.

Case 4

This 66 year old white male was examined in 1958 with a complaint of postprandial epigastric pain and fullness of 20 years' duration. He had not vomited nor had hematemesis, and had maintained his weight. Since an appendectomy,

there had been some right lower quadrant colic and low back pain.

X-ray studies showed a defect in the second part of the duodenum, and partial obstruction. This was interpreted as annular pancreas. Operation confirmed the diagnosis and also disclosed adhesions in the right lower quadrant. An anterior gastrojejunostomy was performed.

The postoperative course was uneventful except for a transient episode of partial intestinal obstruction 11 days after surgery.

Summary and Conclusions

1. The congenital anomaly, annular pancreas, is probably more common than the older literature indicated. The incidence, embryology, anatomy, pathology, radiology, and surgery of this condition have been briefly reviewed.

2. Four adult cases, diagnosed preoperatively, are presented with the roentgen and surgical findings. One of these patients, aged 81, is the oldest with this anomaly recorded to date in the literature.

3. Chronic or acute duodenal obstruction from annular pancreas in the adult may be initiated by superimposed diseases. The clinical symptoms vary directly with the degree of obstruction. Characteristic complaints are postprandial pain and vomiting, usually worse at night. Peptic ulcer and pancreatitis frequently accompany the anomaly.

4. Roentgen examination of the upper



Fig. 5. (Case 3) Spot films showing a greater detail the defect seen in figure 4. Note presence of defect on all views. The appearance is typical in that the defect is more marked on the posterior or outer (lesser curvature) border.



Fig. 6. (Case 4) The persistently narrowed segment of the duodenal loop is noted. The cap is slightly dilated—a common secondary finding.

gastrointestinal tract is the only non-surgical method of making the diagnosis in the adult. Characteristic findings are chronic obstruction with dilatation of the duodenum proximal to the lesion, and the constant, unvarying, smooth pressure defect of the loop of the duodenum. A greater awareness of these findings will result in a higher percentage of preoperative diagnoses of this condition.

5. Treatment of symptomatic cases is best accomplished by a bypassing procedure such as one of the types of gastrojejunostomy.

The 4 patients presented here obtained satisfactory relief of symptoms after operation, but not all patients are as fortunate.

6. Pediatric cases of annular pancreas present an entirely different diagnostic and therapeutic problem, and thus are not discussed in this paper.

Acknowledgements

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It is mainly when the diagnosis is obscure or when the expected favorable course of an illness does not take place that the physician must constantly ask himself "what further test may I do that will solve the riddle or what therapeutic procedure may I carry out that will help matters."—Levine, S. A.: *Worry—Where Will It Get You?* *The Pharos* 23: 214 (Oct.) 1960.

Fluid and Electrolyte Balance of the Anesthetized Pediatric Patient

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DURHAM

Infants and small children are not just "little people." There are qualitative as well as quantitative differences which distinguish their fluid and electrolyte balance from that of adults. Fortunately, infants have great capacities in some respects. Their recuperative powers are sometimes remarkable in spite of what we do or do not do to them. They rarely suffer from chronic or degenerative diseases of the heart, liver, lungs or kidney—all of which impose special problems in the fluid and electrolyte balance of the adult.

Unfortunately, however, infants have very limited capacities in other respects. They cannot tolerate large variations in fluids and electrolytes, as can adults. It behooves all of us, therefore, to consider, calculate, and administer fluids very carefully to infants and small children.

Methods of Calculation

A few figures will be mentioned to serve as a guide for fluid and electrolyte therapy, but it must be remembered that figures and calculations must be tempered by clinical judgment.

First: All fluid replacement should be calculated on the basis of body weight. This is simply because all measurements of fluid loss are by weight. The calculation can be done in three ways:

1. Weigh the infant. Deviations from his normal weight—or, if that is not available, his predicted normal—that cannot be explained on a nutritional basis must be due to fluid gain or loss.

2. Weight (or measure) volume of fluid loss, such as gastric suction, urine, blood in sponges, and so forth.

3. If the foregoing information is not available, and if the child is dehydrated as

determined by history and physical examination, an estimate of 10 per cent of the body weight may be made (table 1). In infants this fluid loss is nearly all water, not water and mineral solutes as in the adult.

Table 1
Physiologic Comparisons Between Newborn, One-Year-Old and Adult

<i>Physiologic Dimensions</i>	<i>Newborn</i>	<i>1 Year</i>	<i>Adult</i>
Weight in Kg.	3.0	10.0	70
Weight in pounds	6.6	22.0	154
Surface area in M ²	.2	.45	1.75
Total body water (cc)	2400	7500	42,000
Blood volume (cc)	240	750	4200
Stroke volume (cc)	12	40	
Cardiac output (cc/min)	1560	5200	
Unavoidable daily fluid loss (cc)	132	440	1400
Dehydration (cc)	300	1000	

Blanks occur where comparisons are not applicable or valid.

M² = square meters.

Cardiac output is based on arbitrary heart rate of 130 per minute.

4. The blood volume is also based on weight and is usually considered about 80 cc per kilogram of body weight in the infant, 75 cc. per kilogram in the small child, and 60 cc. per kilogram in the adult. The blood volume is about 10 per cent of the total body water regardless of size or age, and it is the total body water that decreases with age, mainly because of accumulation of fat. A rough estimate of whether the blood volume is normal or not can be made from the hemoglobin or hematocrit.

Of course any severe departure from the normal fluid volumes should be corrected, preferably at least a day before any surgery or anesthesia.

Second: All fluid requirements should be calculated on the basis of body surface. This is because most physiologic functions are proportional to body surface—for example,

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From the Division of Anesthesia, Duke University Medical Center, Durham, North Carolina.

evaporation of water, and heat loss. These simple proportionalities are of interest.

1. Surface area is in proportion to length²
2. Weight (volume) is in proportion to length³
3. Surface is in proportion to $\frac{\text{weight}}{\text{length}}$

The newborn has one-twentieth the weight of an adult. The newborn has one ninth the area of an adult. The newborn has one-third the length of an adult.

The usual fluid requirement is 1,500 cc. per square meter per day, or, remembering that there are 1,440 minutes per day, 1 cc. per square meter per minute (table 2). For premature infants there is a preset limit of 30 cc. per pound (66 cc. per kilogram) per day. This is about half the value calculated from surface area, probably because the metabolic rate of premature infants is about half what one would expect from the surface area.

Factors Affecting Fluid and Electrolyte Loss

The water loss of an infant is relatively greater than that of an adult, owing mainly to two facts: (1) a higher metabolic rate, with the resultant increase in waste products to be washed out; and (2) the fact that the infant kidney can excrete only hypotonic urine. It has been said of infants that "their total store is depleted at more than twice the rate of adults, and so they die in half the time." The unavoidable daily water loss in the infant, mainly from the lungs, skin, and the urine obligatoire amounts to about 4 per cent (4.4) of their body weight (table 1).

In addition to this unavoidable loss, during anesthesia and surgery additional water will be lost from the lungs, particularly if dry gases and non-rebreathing techniques are used, and from exposed and damaged tissues. This is particularly true in open chest and open abdominal operations.

If there is obvious electrolyte loss, such as occurs with vomiting, diarrhea, draining fistulas, and so forth, this must be replaced, but only after careful measurement. It is far better to err on the side of too little than too much when correcting electrolyte loss in

Table 2
Additional Comparisons Between Newborn, One-Year-Old and Adult

<i>Physiologic Dimensions</i>	<i>Newborn</i>	<i>1 Year</i>	<i>Adult</i>
Weight in Kg.	3.0	10.0	70
Daily fluid requirement			
total (cc)	300	675	2625
cc/Kg.	100	67.5	37.5
drops/min.	12.5	28.2	
Maintenance electrolytes			
sodium (cc of isotonic saline)	40	90	350
potassium (mgm of KCl)	400	900	3500
carbohydrate (grams)	15	31	131
carbohydrate (cc of D ₅ W)	300	680	2620

Note how great an error would occur if daily fluid requirements were based on cubic centimeters per kilogram instead of square meters of body surface.

Drops per minute based on microdrip chamber delivering 60 drops per cubic centimeter.

D₅W = 5% dextrose in water.

infants. Salt, for example, should be considered a dangerous drug and should be given only after careful consideration of dosage. If a young infant is dehydrated, unlike the adult, he should receive only water, not water and salt. There are three reasons why this is true.

1. The infant kidney is underdeveloped in both glomerular and tubular function until the age of six months to 2 years. These functions are usually about 20 to 40 per cent less than would be expected from the calculations based on surface area. The infant kidney is unable to concentrate urine and excrete mineral solutes. For example, the young infant can concentrate urine to only about 700 milliosmoles per liter, as compared with 1,400 mOs. per liter for the adult.

2. During and immediately after anesthesia and surgery these functions are further reduced.

3. If intake of water is low, as it might be before and during an operation, the kidney will tend to conserve what salt it can.

Before anesthesia and operation these steps should be taken:

1. To prevent dehydration as well as for other reasons, children, and especially small infants, should be placed first on the day's operating schedule.

2. Up until four hours prior to anesthesia, fluids should be forced by mouth, if retained; by the intravenous route if not.

3. If there is any reason to suspect dehydration or electrolyte imbalance, get good base-line studies, including weight, electrolytes, hematocrit, urine volume, and specific gravity if possible.

4. Losses from vomiting, diarrhea, draining fistulas, and so forth, should be measured in so far as possible, and replaced. Fortunately, most of these fluids have a composition of about 60 mEq. of sodium, 50 mEq. of chloride, and 30 mEq. of potassium per liter. Solutions closely approximating this are commercially available.

5. If measurements of these losses are not available but it is known that the infant has had, for example, persistent vomiting, it is safe to replace 15 per cent of the fluid loss as saline, preferably not stronger than one-fourth or one-fifth isotonic. Remember, the total fluid loss may be estimated at 10 per cent of body weight if the infant is very dehydrated. An infant 4 days old or less rarely needs electrolyte replacement.

During anesthesia or surgery these steps should be taken:

1. The administration of intravenous fluids, 5 per cent dextrose in water, should be started if the procedure is prolonged (more than one hour), or if the procedure is a major one, such as a craniotomy, thoracotomy, or laparotomy.

2. These fluids should be allowed to run very slowly to prevent overhydration and subsequent pulmonary edema, which can be just as dangerous as underhydration. Kidney function is depressed, as in adults, and consequently a large part of the fluids administered will be retained. Also, it may be desirable to use anesthetic drugs in solution—for example, anectine drip. These amounts are unpredictable, and so must be compensated for by a slow infusion of other fluids.

3. If the infant presents a special problem in dehydration or electrolyte imbalance, serial hematocrit determinations done during surgery can be helpful.

Following anesthesia and operation these steps should be taken:

1. Continue administering any fluids in-

travenously until the oral intake is retained and normal.

2. Replace any deficit acquired during the operation due to fluid losses or because of the slow infusion maintained.

3. If prolonged intravenous therapy is necessary, maintain the basal requirements. Water is calculated on the basis of 1,500 cc. per square meter per day, or 1cc. per square meter per minute. Electrolytes to be given are 30 mEq. of sodium per liter (200 cc. of isotonic saline), 25 mEq. of potassium per liter (2 Gm. of potassium chloride), 25 mEq. of chloride per liter (which is more than supplied by the above saline and potassium chloride), and 75 Gm. of carbohydrate (1,500 cc. of 5 per cent dextrose in water), all per meter squared per day. (fig. 2). Usually the three electrolytes mentioned are dissolved in 1,000 cc. instead of 1,500 cc., giving one and one-half times the minimal requirement. This allows for small losses that may have been missed and does not overload the normal kidney.

4. Determine serial hematocrit and electrolyte levels as deemed necessary.

Blood Transfusions

Hazards

Blood transfusions in infants deserve even more care and consideration than do other types of fluid therapy. There are three major dangers of transfusions. The first is the possibility of a reaction due to incompatibility. This danger can be reduced to nearly zero by very careful cross matching (not just typing of the cells and serum and careful checking of the blood slips and bottles (preferably by two persons). Even so, some rare blood groups can cause trouble. The second danger is that of homologous serum jaundice. This danger still exists in spite of much effort to eliminate it. The third is the danger of overtransfusion, leading to pulmonary edema.

There are also dangers associated with not giving blood transfusions when they are needed. Hypovolemia may lead to hemorrhagic shock, will produce too deep a level of anesthesia if the dosage of anesthetic

agents is not reduced proportionately, and will prolong the postanesthetic recovery period. Thus under-transfusion adds to the operative and postoperative morbidity and mortality just as surely as does overtransfusion.

Calculations

Here again, all measurements and calculations must be tempered by clinical judgment, and the decision of whether to transfuse or not, and how much, is sometimes very difficult.

Good base-line studies are imperative before anesthesia and before operation. Both hemoglobin and hematocrit determinations should be done if possible. If only one of these determinations is done, however, one is committed to use the same test during and after the operation. Comparisons between hemoglobin and hematocrit in rapidly

Table 3
Average Hemoglobin Values in Healthy Children*

Age	Hemoglobin (Grams per 100 cc. of whole blood)
Birth	17.6
2 days	18.0
14 days	17.0
3 months	11.4
6 months	11.5
1 year	12.2
2 years	12.9
4 years	13.1
8-12 years	14.1

*Based on figures many years old. With better nutrition, these averages are probably higher now.

changing states of fluid imbalance are not valid. Urine volume and specific gravity determinations should also be done, if possible, as these values will give more validity to the hemoglobin and hematocrit determinations when used as indications of blood volume.

The hemoglobin varies greatly during the first year of life (table 3). An arbitrary minimum of 10 Gm. of hemoglobin per 100 ml. or 30 per cent hematocrit may be chosen, however. If the infants hemoglobin or hematocrit are below these limits, a transfusions

of about 10 cc. per kilogram (12 per cent of the blood volume) should be given, preferably over a period of one hour or longer. This should raise the hemoglobin about 1 Gm. If it does not, a second transfusion of the same amount is indicated (table 4).

Table 4
Volume of Blood That Can Be Safely Given Single Transfusion

Age	Total Blood Volume (cc.)	Single Transfusion*
0- 6 months	450	50
1- 2 years	630	65
4- 5 years	1070	100
8- 9 years	1600	150
11-12 years	2190	200

*This amount varies from about 12% of the total blood volume in the infant to 9% in the adult. The volume should be given over an hour's time or longer.

During the operation a gradual hemorrhage of 10 cc. per kilogram or more is probably indication for a transfusion. Remember that 1 ounce (about 30 cc.) of blood in a newborn infant is equivalent to 500 cc. in the adult. If it is almost certain that a transfusion will be needed, it is far better to replace the lost blood, drop for drop, as it is lost than to wait until 12 per cent of the blood volume is lost. The same figure (10 cc. per kilogram given over a one-hour period) can be used here. If the bleeding is brisk, however, this amount may be safely doubled without danger of overloading the patient. With a cardiac output six times the total blood volume, it can be easily understood why an infant cannot tolerate very much blood loss. (table 1)

Although blood loss is extremely difficult to estimate in infants, the attempt should be made. Careful weighing of sponges, measuring of suction, using little or no saline for irrigation, and weighing the infant before and after surgery, all make valuable contributions to this estimation. Frequently, however, particularly with large losses, this estimation may be so far off that one will have to rely purely on clinical judgment. Such signs as tachycardia, decreased blood pressure, pale color, poor capillary return, and poor quality of the heart sounds are valu-

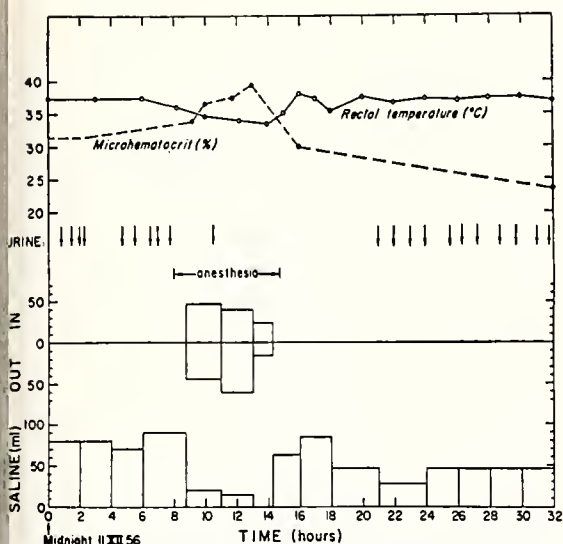


Fig. 1. An example of the value of serial microhematocrit determination in an infant (4 months old) during major surgery. Dotted line (solid points) indicates hematocrit in per cent. Note: Falsely high hematocrit due to dehydration. Patient was given additional transfusion to correct this the next day. See Reference 4 for details.

able clinical indications of hypovolemia. Serial hematocrits using a microtechnique may be done at frequent intervals during major procedures. This has been found to be a valuable adjunct in estimations of blood volume (figure 1). It should be emphasized that serial determinations, combined with other information such as urine volumes and specific gravities, are far more informative than a single determination. The micro-method is easily repeated. The samples are small, so that duplicate or triplicate determinations may be done without exsanguinating the patient. The technique demands a free flow of blood from a puncture wound, careful sealing of the capillary tube, and some practice in reading.

Postoperatively, blood replacement should be completed. After operative fluid deficits, as described previously, have been corrected, the urine, specific gravity, and hematocrit determinations should be repeated. If the hematocrit has then dropped far below the normal or preoperative level, further blood replacement must be considered.

Subcutaneous Administration of Fluids

Subcutaneous fluid therapy has no place

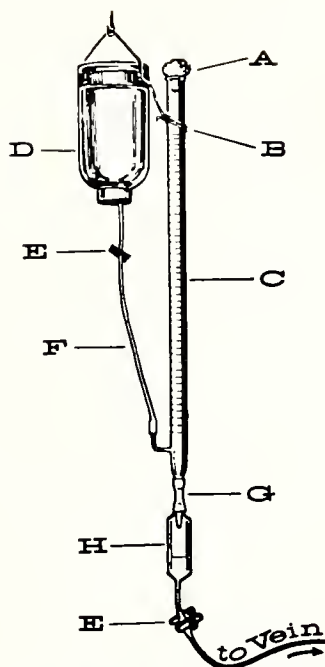


Fig. 2. Homemade pediatric blood transfusion set. A. sterile cotton plug. B. string support. C. 50 cc. standard chemistry burette (readable directly in 0.1 cc.). D. standard blood storage bottle. E. positive sealing slide clamp and fine control screw clamp. F. standard extension tubing. G. rubber tubing. H. drip chamber. Note: Blood is delivered to the patient only from the burette with the storage bottle securely clamped off.

in pediatric anesthesia. Saline will diffuse into the subcutaneous stores and cause water and salt depletion before these depots of fluid are absorbed. This will actually aggravate the dehydration of the infant temporarily. It also presents the danger of local tissue damage and sloughs.

All fluids that cannot be taken orally should be given intravenously, preferably through large needles. Number 20 needles are used on small infants, and frequently number 18 on large infants and children. Some people object to the use of large needles on the grounds that large volumes of fluid may be inadvertently given through them. It is believed that a large bore needle through which one can pump blood in a hurry, if necessary, is the anesthetist's right hand. It would seem foolish, therefore, to handicap oneself by tying his right hand behind him, so to speak. If he uses good clamps of the screw variety and never places more than one half of the daily dose of fluid

in the bottle at one time, the danger of flooding the patient is very small. This means that no infant should have more than a 200 cc. bottle attached to the intravenous apparatus (100 cc. if he is very small or very sick). Similarly, a larger child should be limited to a 500 cc. reservoir. Special apparatus may be employed for very small infants or in special cases (Fig. 2). If needles cannot be placed in a vein easily, a cut down should be done, preferably under local anesthesia, to save anesthesia time in small infants. The use of some sort of microdrip equipment is very handy in pediatric work. Some of these sets will give 60 drops per cc., and at 1 cc. per square meter per minute, a new born infant (0.2 square meter) would receive about 12 drops per minute (figure 2). Anyone can regulate the drip to this rate without great difficulty.

Summary

Factors affecting fluid and electrolyte balance in infants and children have been discussed and methods of estimating and replacing losses sustained during anesthesia and surgery have been detailed. Special attention has been paid to the hazards involved in replacing blood. Techniques for administering both blood and other fluids are explained in detail.

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Endotracheal Intubation and Complications in the Pediatric Patient

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In the pediatric patient, to intubate or not to intubate is a controversial question; but listening to a child crow because of light anesthesia allowing reflex laryngospasm, or seeing him barely breathing because of deep anesthesia being inadequately assisted, or not at all, makes one rapidly become prejudiced in favor of the endotracheal tube.

True there are hazards and complications associated with intubation. These, however, can be minimized with experience and with constant attention to every small detail so that the advantages far outweigh the disadvantages. Pediatric anesthesia of any type is not simple. Indeed, it requires unrelaxing vigilance from the moment of induction until the child has regained all his protective reflexes and is awake again. The presence of a tube in the trachea makes this even more mandatory.

In this age group the cardiovascular system has an inherent automaticity and regulatory power; it is the respiratory system that is prone to alterations. With the reduced margin of safety that exists in the pediatric patient, the establishment of an adequate airway is more than half the battle.

Indications

In our institution more than 60 per cent of all pediatric patients and almost all in the group less than two months of age are intubated. Definite unequivocal indications for the procedure are:

1. Operations on head and neck structures where the anesthesiologist must be removed from the operative field and has no control of the airway, unless he extends it by means of a tube.
2. Operations on patients in the prone or lateral position, which interferes with maintenance of a patient airway and

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adequate respiratory excursions, as well as results in uneven distribution of pulmonary blood flow and alveolar gases.

3. Operations on the open chest in pulmonary and cardiac surgery requiring assistance or control.
4. Operations on children with full stomachs or distended bowel to prevent the dire complications of aspiration.

Advantages to Infants

Infants up to 2 years, and especially premature infants and ill children, have a smoother anesthetic course and less physiologic disturbance when the endotracheal tube replaces the conventional mask. In the infant, respiratory exchange is efficient only if he is normal or is under normal conditions. He can not meet the increased demands of illness or surgery. Chest movements are inefficient. The sternum is soft, and so is an unstable basis for the ribs. In the premature infant it may even invert with each inspiration.

The ribs of the infant are horizontal, thus eliminating the bucket-handle motion of adult thoracic respiration. Movement of these ribs, therefore, causes little increase in the size of the thoracic cage¹. Intercostal muscles are poorly developed, while accessory muscles give little assistance. Most of the air movement is due to the diaphragm. But the diaphragm is high and its motion embarrassed by large abdominal organs such as the spleen and liver. It is further limited by the prone position as well as by gaseous distention, which results readily from swallowing air or from assisted respiration with a bag and mask. Using a small Levin tube will prevent this gastric dilatation and further limiting of diaphragmatic movement.

Lung volumes are small. The total lung volume at birth is 175 cc. This increases rapidly the first year to 400 cc., slows down the second year, increasing only to 500 cc., then increases in proportion to the weight of the child.

Tidal volume in the newborn is 10-25 cc. and in the premature only 5-12 cc. Increased demand is met by increased rate. Only

after the second year can the infant increase tidal volume; then rate becomes a reserve mechanism. When one considers the anatomic dead space of 1 cc. per pound of body weight, one can see that increasing rate adds very little to increased alveolar ventilation. Increased tidal volume is what is needed.

Adding to dead space by using a mask can cause it even to exceed the small tidal volume and result in ineffective gaseous exchange and carbon dioxide retention. At one year the smallest usable mask has a dead space of 50 cc. This added to the natural dead space of 16 cc. in an infant with a tidal volume of 80 cc. results in an alveolar ventilation of 14 cc., one-fifth normal. Thus a means not only of decreasing anatomic dead space, but also of avoiding additional mechanical dead space is necessary.

The respiratory center in this group is immature and unable to withstand oxygen lack. The characteristic irregular respiration of the newborn is an anoxic pattern, and can be converted to regular respiration by 100 per cent oxygen. It is true the hemoglobin is usually fully saturated on room air, but fetal hemoglobin does not readily give up oxygen to the tissues. Adding oxygen to the inspired air increases the amount in physical solution, and thus it is immediately available for use. General anesthetics will readily depress this immature center, and assisted respiration is required in the majority of instances.

The upper respiratory tract is easily predisposed to obstruction. The infant breathes mainly through his nose, as the large tongue has a ball-valve action against the palate. The nasal passages, glottis, and trachea are relatively small and become easily obstructed by overgrowth of lymphoid tissue or a small amount of secretion. With the infant's weak muscle power, it is quite difficult to keep an open airway while rendering him unconscious. This difficulty can be overcome by intubating while he is awake.

Although the infant thorax is more compliant than that of the adult, the lungs are only half as compliant on a lung weight

basis². Flow resistance, which is inversely related to the fourth power of the radius of the tube, is 15 times greater, as the infant trachea and bronchi are about one-fourth the diameter of the adult. With his increased demand for oxygen and for clearance of carbon dioxide, and with his relatively large physiologic dead space, the baby has to shift proportionally twice as much air as does the adult in order to produce adequate gaseous transfer. These three factors result in the utilization of a great deal of energy for the work of breathing even under normal conditions.

Increased resistance due to mechanical devices, partial respiratory obstruction from inflammation or accumulation of mucus, and carbon dioxide retention leading to rapid, forceful respirations greatly increase this work of breathing and may end in complete exhaustion of the child. Under such circumstances large tidal volumes at low respiratory rates will be more efficient in relation to the work of breathing as well as to better ventilation itself. But these infants respond with increased rates. We have to supply the increased tidal volume.

At this age the laryngeal reflexes are very active and troublesome. They are only obtunded in the third plane of anesthesia, so that reflex laryngospasm can be precipitated easily if the anesthesia is light. They also prolong induction with ether. With their small functional residual capacity and residual air and their high consumption of oxygen, infants have very little reserve against anoxia resulting from laryngospasm. Alveolar oxygen is totally depleted in 2 to 3 minutes in the nonventilated infant lung.

Intubation in the infant, therefore, is indicated (1) to overcome the anatomic obstruction of nose, tongue, and larynx; (2) to eliminate mechanical dead space and decrease anatomic dead space; (3) to permit minute-to-minute control of respiration as well as the plane of anesthesia; and (4) to facilitate the effective assisted or controlled respiration so necessary to overcome the inefficient chest movement and decrease the work of breathing, thereby preventing undue fatigue resulting from the increased resistance. Increasing the tidal volume and

thus increasing alveolar ventilation is the most important principle in pediatric anesthesia.

Advantages to Older Children

Older children, as well as infants, benefit from intubation for the preceding reasons, although probably it is not as mandatory for them. Prolonged procedures in this age group definitely require assisted respiration and very light planes of anesthesia. The endotracheal tube permits this assisted respiration without distention of the stomach, and allows a higher plane of anesthesia to be maintained without worry of laryngospasm, stridor, reflex apnea, or aspiration of vomitus. In intraabdominal procedures, the use of muscle relaxants can be used safely if the trachea is intubated. Troublesome traction reflexes associate with laryngospasm may still occur, but the airway is patent and anesthesia can be deepened quickly³.

Precautions

Just because a tube is in the trachea one cannot happily go one's way without a thought about obstruction. This still can happen. The trachea in the newborn is relatively short—about 4 cm. It does not increase in length rapidly and at 2 years is only 5 cm., at 6 years 5.7 cm. With too long a tube one can easily intubate a bronchus, thus causing atelectasis of the opposite lung. This can occur on either side, as each bronchus branches at an angle of 55 degrees from the trachea. Only after the third year does the right bronchus form a more acute angle with the vertical than does the left, and is more readily intubated. Marking the tube 1 inch from the end and inserting it to that mark, then checking each side for breath sounds insures against bronchial intubation.

Obstruction of the tube can result from kinking either in the pharynx, at the lip margin, or at the connection with the angle piece. It is wise to check the patency after the tube is in place by running a measured catheter through its entire length. Placing two towels under the shoulder hyperextends the neck and straightens out the pharynx.

A bite block will prevent pressure on the tube by the teeth. Constant monitoring of breath sounds and heart rate with a precordial stethoscope is the sine qua non of good pediatric anesthesia. Tubes can be blocked with foreign material before insertion or can become blocked by inspissated mucus during long operations with the use of high flow of dry gases. This can be prevented by frequent aspiration with a measured catheter; otherwise reintubation will become necessary during the operation.

Insertion of a tube decreases the diameter of the airway, and in the little ones this can be an important factor in adding to resistance to air flow. According to Poiseuille's law, resistance varies indirectly with the fourth power of the internal radius of the tube, so the largest, thinnest-walled tube that can be easily inserted should be used and respirations assisted. Trauma can result from rough manipulation, especially in a poorly relaxed child. Sore throat, hoarseness, or coughing may follow. Infant gums, which are a series of segments of active vascular tissue, can be indented easily. If distortion should occur, the gum should be remolded. Accidental removal of teeth, especially the central incisors, occurs readily around the sixth or seventh year, when their deciduous roots are absorbed and the teeth are only superficially embedded. One should make every effort to locate the dislodged tooth even if an x-ray is required. A tooth left in a bronchus can lead to medicolegal complications.

Hemorrhage can result from catching the lip between a tooth and the laryngoscope, from gouging out a piece of the posterior pharyngeal wall with the tip of the blade, or from removal of adenoid tissue by a nasal endotracheal tube. Using a light, easily handled laryngoscope with a narrow blade having a blunt end will tend to reduce trauma.

Postoperatively, supraglottic or subglottic edema can occur. Although the mucosa is rigidly adherent to the posterior epiglottis, it is loosely attached anteriorly and along the aryepiglottic folds. Edema in these areas can push the epiglottis in and back to occlude the larynx. Soft areolar tissue below

the level of the vocal cords can become edematous and can occlude at the cricoid, the smallest and most rigid part of the trachea in children. In infants, where the diameter of the cricoid is 4 mm. and the cricoid area is 14 mm. squared, 1 mm. of edema can decrease this opening to 5 mm. squared, or to 35 per cent of normal. In adults, the same amount of swelling would decrease the opening only 19 per cent.

Edema follows the forced insertion of too large a tube into the trachea, prolonged tubation, frequent movement of the larynx on the tube, or infection. Infection, perhaps, is the most frequent factor implicated in this complication⁴. It can follow the use of contaminated tubes or lubricants and readily occurs in children with pre-existing upper respiratory infections or fluid imbalance.

Hoarseness and laryngeal stridor are occasionally seen, but severe laryngitis is not too common if one is careful. Retraction of the supraclavicular and intercostal spaces indicates inadequate flow rates, and rapid respiration indicates carbon dioxide retention. Constant vigilance is needed, as the rapid breathing through a narrow glottis can result in exhaustion from pulmonary edema.

To minimize this edema, intubation should be gentle and the patient well relaxed. Bucking or straining on the tube should be prevented by adequate depth of anesthesia and minimal movement of the head or tube. Pliable plastic tubes should be used, as these will mold to the shape of the trachea with the heat of the body. Rigid rubber tubes should be shunned, since they cause pressure on the posterior pharynx, arytenoids, and anterior tracheal wall. The tube should be scrupulously clean having been washed with soap and water, rinsed, soaked in Zephiran for 30 minutes, rinsed again, and stored in a clean case. Cuffs are not needed in children, and only cause additional pressure.

Postoperative Care

Postoperatively, all infants and the children subjected to prolonged or traumatic intubation should be placed in a cold, moist

atmosphere for 12 to 24 hours. This can be satisfactorily supplied by the Isolette in infants and the Croupette in older children. Not only will the edema subside, but the lowered body temperature will decrease the oxygen demand and carbon dioxide production, with subsequent quiet, slower respiration. Sedatives are helpful in slowing respiration and preventing pulmonary edema. They should be given only if there is no respiratory obstruction and the restlessness is not due to hypoxia. Atelectasis is prevented by frequent coughing and endotracheal suction. Adequate fluid intake is important both pre- and postoperatively, as dehydration increases temperature and respiratory rate and causes further irritation of the laryngeal edema. If no improvement occurs in six hours, a tracheostomy should be considered. It should be done earlier if the respiratory rate remains over 36 and the pulse rate over 140.

Objections

Prolonged inductions in order to attain third plane for an atraumatic intubation is no longer an argument against intubation. Children below the age of 6 months can be intubated awake, while the older child is relaxed by the use of intramuscular or intravenous succinylcholine. Topical agents applied to the larynx allow many patients to be intubated with the use of cyclopropane or fluothane alone. Both Pontocaine, 1.5 mg. per pound, and Xylocaine, 15 mg. per pound, have been found to be satisfactory and safe.

Spasm can occur on extubation, and this period may be as dangerous as intubation. Some believe the tube should be removed while the patient is still deeply anesthetized, but the possibility of vomiting and aspiration is very real at this time. We extubate when the patient is in light anesthesia and has regained his swallowing reflex. Laryngospasm will not occur if the respiratory center is not obtunded by anesthetic agents. All secretions from the pharynx should be removed before extubation, so that none is left to irritate the vocal cords. The previously mentioned topical agents will help by suppressing the laryngeal reflex. The

patient should be well oxygenated before extubation, and the practice of dragging the suction catheter out with the tube is to be deplored⁵. Suction can deplete the oxygen reserve in the lung, and if a complete laryngospasm then occurs after extubation, severe anoxia and cardiac arrest result. Immediately after extubation, 100 per cent oxygen should be given by bag and mask. Oxygen is the best prophylactic as well as the best treatment for laryngospasm.

The last objection to intubation is that it is difficult. Intubation is no more difficult in the young than in the adult if one remembers the difference in anatomy. The larynx is more anterior and cephalad, with the cords at a 45 degree angle to the anterior pharyngeal wall, running upwards and posteriorly. This is due to the proximity of the hyoid bone to the thyroid. The epiglottis is stiff, U shaped, and not broad and mobile as the adult's⁶. The curved blade increases further this anterior displacement, while it is difficult to lift the epiglottis with the straight blade and the arytenoids are easily traumatized. The straight blade, however, used in the vallecular space anterior to the epiglottis and pressed in a posterior direction will bring the larynx easily into view. Because of the concavity and slight inferior anterior attachment of the cords, the tip of the tube will impinge on the anterior wall. Lowering the laryngoscope will now straighten out the acute angle of larynx with the trachea, and the tube will easily advance down the trachea. Except for the constriction at the cricoid, other resistance such as subglottic web or tracheal atresia is rare. Thyroglossal cysts, cystic hygroma, and mucous cysts of the epiglottis are also rare, and do not make intubation difficult.

Summary

With intelligent use, intubation facilitates all pediatric techniques. Safe light planes of anesthesia can be maintained without fear of respiratory aberrations. The tube has been the major factor in lowering surgical mortality by making anesthesia more physiologic, more controllable, more predictable, and more reversible. Disaster can be

etter avoided in the intubated infant and child.

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Anesthesia for Pediatric Orthopedic Procedures

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DURHAM

The fact that mortalities due to anesthesia occur more often in the first decade of life than any other¹ cannot be ascribed to status mycolymphaticus or any other pathologic condition, real or apparent, which is peculiar to the child. With but few exceptions, usually embracing congenital anomalies, the myocardium is functionally strong and contractile, the arteries are patent and pulsatile, and the vital organs are richly supplied with capillary plexuses. Moreover, pulmonary disease which limits the normal oxygenating function of the lung is rare in the child presenting for operation. The fatal complications occur for the most part because the margin of allowable error in providing anesthesia for the child is less than in other age groups. Hypoxia due to acute or chronic respiratory tract obstruction can be precipitated more easily in the child because of the small anatomic size of the airway structures. Acute lack of oxygen wrecks the machinery of cellular metabolism more rapidly because the oxygen in the functional residual dead space of the lung is exhausted quickly from the small lungs of the child. Because of the small size of the child, over dosage with potent anesthetic drugs can occur rapidly, and often with virtually no remonitory signs.

These dangers are common to all children subjected to anesthesia. Certain practices tend to protect the child from these hazards. Among them may be included an adequate

preanesthetic evaluation and the provision of proper preoperative medication.

Clinical Evaluation

In addition to the physical examination performed during the clinical evaluation of a child for elective operation, one is concerned about the presence of an intercurrent infection associated with upper respiratory tract obstruction or pyrexia. Children with fever who are perhaps dehydrated and who are then exposed to drugs such as ethyl ether are prone to develop convulsive episodes during operation: the danger of these is well known. The hazard of anesthetization in the presence of inadequate amounts of circulating hemoglobin is beginning to be recognized more fully. If the hemoglobin is reduced by one-half, only half the physiologic amount of oxygen can be carried in the blood stream to the vital organs, even when all other conditions are ideal: under anesthesia these conditions are often not ideal. The hemoglobin value of a child should be at least 10.0 Gm. per 100 cc. of blood before anesthesia and operation are attempted. In orthopedic anesthesia, one is particularly concerned about the child suffering from cerebral palsy. In these patients secretions are more likely to develop during anesthesia, and those with more severe involvement require and tolerate only low concentrations of drugs. It is therefore important to evaluate the degree of central nervous system abnormality in these patients.

In emergency operations—and these are prevalent in orthopedic practice—the clin-

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Fig. 1. Superficial landmarks for blocking major nerves in upper arm.

ical evaluation, in addition to the above factors, must include careful note of the prior ingestion of food or fluids. If the child has eaten or consumed fluids within the four hours prior to or at any time since the accident, it must be presumed that he has food or fluid in his stomach. As a general rule, digestive processes stop at the time of a psychic and physical insult. There can be no rationalization in this matter and no compromise. Any type of general anesthesia under these circumstances will endanger the life of the child. The proverbial "whiff of gas" or the "minute or two of intravenous anesthesia" are just as dangerous as the "major" anesthetic for a major operation. Neither the surgeon nor the anesthetist should be trapped or enticed into precipitating a preventable death².

What can be done under these circumstances? There are several potential alternatives. Ideally, pain can be relieved with some form of regional analgesia. With adequate preoperative medication, such a choice is not impractical. For the lower extremity, spinal analgesia is a simple technique³, and for the upper extremity block of the major nerve trunks in the upper arm is valuable and free of complications (fig. 1)⁴.

A second approach is to induce vomiting in the child. This must be done thoroughly and therefore cannot be done gently. Regurgitation and aspiration of liquid acid in the gastric contents during operation is just as dangerous as the inhalation of solid particles. The best way to evacuate the stomach is to pass a large stomach tube and then

employ repeated gavage, as in a case of poisoning.

A third alternative is to postpone operation for 8 to 10 hours, attempting to sedate and induce sleep in the child during the interim. This method is not foolproof, and the stomach may not be empty even after this period of time. If there appears to be no other choice, an open drop vinyl ether-ethyl ether sequence may be attempted by an expert anesthetist. This technique should be considered a final, remote alternative. Theoretically, when this method is being used, if the patient is going to vomit he will do so as he is passing from the second to the third stage of anesthesia, at which time the vomiting reflex is stimulated with this type of anesthesia. Usually, but not always, the protective laryngeal reflexes are still active at this stage, so that aspiration is less likely. However, severe hypoxia will accompany the protective laryngospasm. Emergence from anesthesia is perhaps even more dangerous when this type of anesthesia is employed in a patient whose stomach is not empty.

Preoperative Medication

It is important for the emotional equilibrium of the child that he be given the benefit of preoperative medication. Many different schedules have been suggested; the aim is to have a child who comes to the operating room sufficiently carefree to doze when left alone, but responsive in a nonapprehensive manner to the spoken word. We have found that these ends can be met by administering a short-acting barbiturate (pentobarbital) along with a narcotic (morphine) and an anticholinergic (atropine or scopolamine, preferably the latter) (table 1). Proper dosages according to weight are important. Scopolamine not only produces a good drying effect, but also has a cerebral sedative action which reinforces the other sedative drugs. In orthopedic patients who frequently return to the operating room several times, such preoperative medication obviously is beneficial. If the child is being sedated prior to regional analgesia, the recommended dosage of preoperative medication can be increased safely.

Table 1
Suggested Dosage of
Preoperative Medication
in Children

Age	Weight (Pounds)	Nembutal Oral* (Mg.)	Morphine (Mg.)	Demerol (Mg.)	Scopolamine (Mg.)	Atropine (Mg.)
Up to 6 mos.	7-16				0.1	0.1
6-12 mos.	17-19				0.1	0.15
12-18 mos.	19-24			13	0.1	0.15
18-24 mos.	24-27			13	0.15	0.2
2-5 yrs.	27-40	15	0.5	18	0.2	0.2
5-8 yrs.	40-55	30	1	25	0.2	0.3
8-10 yrs.	55-65	45	2	37	0.2	0.3
10-12 yrs.	65-80	60	3	50	0.3	0.4
12-14 yrs.	80-90	60	5	75	0.4	0.4
Adult	over 90	90	8:15	100	0.4-0.8	0.4-0.8

* Rectal dosage about two times above doses.

1. Individualize doses according to physical and mental status of patient.
2. Scopolamine has central sedative effect and counteracts respiratory depression of narcotics.
3. Doses of barbiturate indicated do not depress respirations.
4. Administer barbiturate two hours preoperatively; morphine or Demerol, scopolamine or atropine on call.

Basal anesthesia induced by the rectal administration of Avertin or an ultrashort acting barbiturate (thiopental) has achieved a certain popularity among orthopedists as a substitute for preoperative medication. It is true that this technique provides a pleasant way for the patient to go to sleep, but it has the disadvantage of continuing action for four to eight hours, so that often the patient is not alert for several hours postoperatively. With the new and pleasant methods of anesthesia induction now practiced in children, we do not believe that the incorporation of basal anesthesia offers advantages.

Maintenance of Anesthesia

Ethyl ether is probably the commonest

drug employed for maintaining anesthesia in children, at least in this part of the country. For the administrator it provides a relatively wide margin of safety, but it is explosive, it is unpleasant for the patient when employed for induction, and its administration is associated with a high incidence of nausea and vomiting postoperatively. Explosive anesthetic drugs provide a real problem in orthopedic surgery when so frequently it is desirable to use the cautery. In our clinic this problem has been solved to a large degree by the introduction of Fluothane into anesthetic practice⁵. This fluorinated compound is nonexplosive and, when used with properly calibrated vaporizers and, with due respect for its potency, is proving to be of great value in orthopedic

surgery. It provides a rapid, smooth induction and will permit in safe concentration a degree of muscle relaxation which is satisfactory for most orthopedic procedures. In our hands it has proved to be particularly useful in children. Recovery from anesthesia is extremely rapid, the patient being oriented as to time, place and person within 10 minutes of the end of operation. The incidence of postoperative nausea and vomiting is less than 5.0 per cent.

One problem peculiar to orthopedic surgery is the frequent employment of tourniquets on the extremities. In children the period associated with the release of the tourniquet may be hazardous, as it is often associated with a marked hypotension. The reason or reasons for this cardiovascular upset are not clear; it may be due to the sudden increase in the circulatory bed of the patient; it could result from the sudden release into the general circulation of partially metabolized substances from the anoxic extremity; it could be due to the sudden increase in circulating potassium which is apparently associated with release of tourniquets. It is important to be alert to this possibility of trouble; it can be ameliorated possibly by gradual release of the tourniquet over a period of one to two minutes. If two tourniquets have been employed, a five-minute interval should separate the release of each.

Minor Surgery

Many orthopedic procedures can be categorized as minor, in that only a short time is required for their completion. However, the administration of anesthesia which may be required can never be considered a minor procedure, particularly in children. Catastrophes are just as likely to occur in a short procedure as in a lengthy operation: the patient travels over much

of the same anesthetic journey in each instance. We would therefore urge that minor operations involving anesthesia be conducted where full facilities are immediately available to take care of emergencies that may arise. An inadequately equipped outpatient clinic without trained personnel is not the place to administer general anesthesia. Take the patient to the operating room where full facilities are available.

As one might expect, anesthesiologists are finding the new drug, Fluothane, of particular value in short orthopedic procedures. The rapid recovery from anesthesia and the minimal nausea and vomiting permit the early release of the patient to his parents.

Conclusions

When all is said and done, the safety of the anesthetic administration depends directly on the knowledge, skill, and attentiveness of the individual at the head of the table. We in the specialty of anesthesia are attempting to improve this factor of safety constantly. Cooperation and communication between the surgeon and the anesthesiologist relating to the peculiar problems involved in different patients will go far toward raising the standard still further.

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News and Views on Present and Future School Health Programs

DONALD A. DUKELOW, M.D.*

CHICAGO, ILLINOIS

At this meeting we have heard authoritative discussions about dental disease, hearing loss, visual defects, accidents, programs designed to develop youth fitness, continuous health supervision of school age children, and assistance to children who have special needs. These kinds of problems are discussed in most school health conferences. They are thought to be problems of children, but actually they are problems of adults—the adults who are responsible for these children.

Current Needs

The objectives indicated by the papers we have heard are reached because of, or in spite of, the attitudes of adults and their ability to communicate with each other. Four major problem areas can be mentioned: (1) The need for the establishment of a child-centered program; (2) the need for more personal and family responsibility and for getting away from the concept that the only way a job can be done is with federal grants or state appropriations; (3) the need to develop the ability and the willingness to communicate across professional lines and with the consuming public in order to develop cooperation; (4) the need for a missionary zeal in the promotion of medical and educationally sound school health programs. A word on each of these might illustrate the point.

Child-centered programs

Competition between schools rather than an effort to improve the child and make him a more effective citizen too frequently characterizes our school health programs. Since the child is the only possible excuse for having a school health program, he should be the center of the program, the

objective of all effort. If we do for the child those things which will protect his health and aid him to live more effectively, and at the same time give him the understanding, the motivation and the independence that will permit him to assume responsibility for himself, his family and his community, we have gone a long way forward.

Family responsibility

Federal grants, as we know them in public health work, were started during the First World War and became firmly established before 1940. Many agencies now feel that the only possible way to accomplish an objective is with a federal or state grant. The development of individual initiative, the cultivation of private grants, and above all the encouragement of family responsibility to care for their own seem to be outdated. Actually, when the care gratuitously given to young people is increased, they are increasingly prone to lean upon government for more and more and to be less willing to assume responsibility for themselves. Even though there are occasions when governmental assistance is necessary in the development of a program, we must be extremely careful lest we thereby prevent the individual and his family from accepting their proper responsibility.

Communication

Each profession has its own language. This language is as foreign to non-members of the group as though it were the language of another country. Communication in intelligible terms, therefore, becomes rather difficult, particularly when the same word holds different connotations for the various professions. Moreover, the educational experiences of one profession differ widely from those of another. It is difficult for the teacher to appreciate the doctor's day, and likewise for the doctor to know all that goes on in the teacher's life, even though each

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From the Department of Health Education, American Medical Association.

has spent some time in the rooms devoted to the others' occupation. In spite of these language problems, understanding and cooperation among professional groups and community organizations is necessary to a sound school health program. Every effort should be made to develop an understanding that will permit intelligent working together.

Promotion of sound practices

In this world of superlatives, where nothing is large and everything is giant, it takes extraordinary persuasive power to interest communities in the support of such prosaic activities as health services for keeping well children well. For that matter, difficulty often is encountered in the development of services that will help to discover those who are not well. Not infrequently unsound programs develop because of enthusiasm that is not founded on fact. Therefore, it seems incumbent upon all concerned to devise programs that are both educationally and medically sound, and to promote them with a zeal that will insure their adoption despite lethargy or open antagonism on the part of some poorly informed citizens.

Views of the Future

Thomas Huxley once pointed out that every new concept begins as hearsay, evolves into orthodoxy, and ends as superstition. In school health we are now somewhere between the first and second stages. An occasional physician, as well as an educator here and there, regards what we consider good school health as rank heresy, though a great majority of thinking professional people accept it as orthodox. It is a part of the good school. The better programs have a smooth relationship with community organizations and governmental agencies as well as with the practicing professions involved in the health service of children.

To prevent the current orthodoxy from degenerating into superstition, we must consciously keep alive the sound practices of the second stage. To do this in a changing world can be difficult. Let us look into the crystal ball to see if the reflection of what

has gone before can give us an insight into what the future might hold. To step into the future effectively, one must have one foot firmly planted on the present.

Medical association activities

At each National Conference on Physicians and Schools information is reported regarding the school health activities of the several state medical associations. The report for the Eighth National Conference to be held next March will include the following activities engaged in by medical associations in the United States:

1. Cooperation with or membership on a state school health advisory committee.
2. Conferences between physicians and educators.
3. Promotion of sound immunization practices.
4. Conferences on athletic injuries and medical aspects of sports.
5. Advice on safeguards for contact sports in the elementary and junior high schools.
6. School health workshops for school administrators.
7. School health workshops for teachers.
8. Advisory services to school health committees of local medical societies.
9. Continuous health supervision of children as recommended by the National Congress of Parents and Teachers.
10. A guidebook showing school health services available from various organizations, agencies and professional personnel.
11. Definition and publication of the professional qualifications and functions of a school physician.
12. Reorganization of existing health programs. Conferences on youth fitness.
13. Promotion of health, safety, and physical education in the grade schools.
14. Promotion of physical education and sound health instruction in the secondary schools.
15. Preparation of articles on school health for publication in education journals.
16. Advice on nutrition. Visual and hearing programs.



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PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

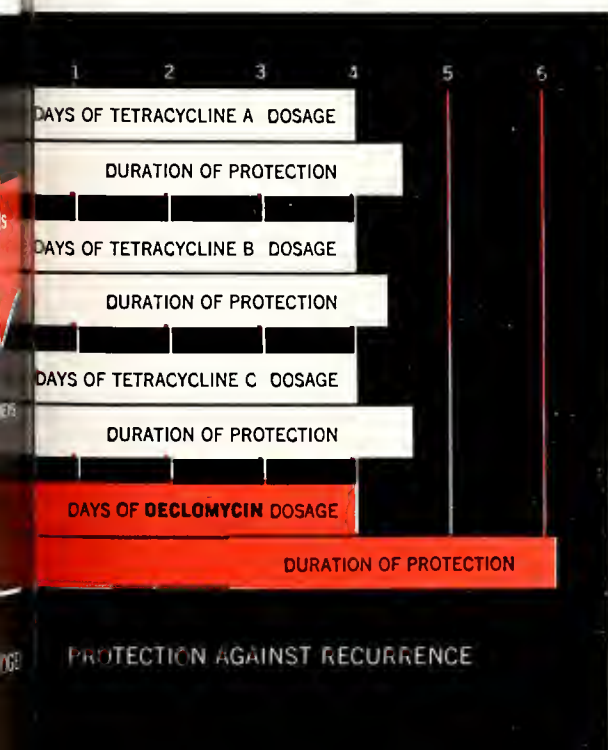
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			Annual Premium	Semi-Annual Premium	Annual Premium	Semi-Annual Premium
5,000	5,000 to 10,000	50.00 Weekly	\$ 78.00	\$ 39.50	\$104.00	\$ 52.00
5,000	7,500 to 15,000	75.00 Weekly	114.00	57.50	152.00	76.00
5,000	10,000 to 20,000	100.00 Weekly	150.00	75.50	200.00	100.00
5,000	12,500 to 25,000	125.00 Weekly	186.00	93.50	248.00	124.00
5,000	15,000 to 30,000	150.00 Weekly	222.00	111.50	296.00	148.00

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Many other reported activities based on local situations were unique to the state reporting. These programs indicate the potentialities of medical association school health committees, since in most instances fewer than half the medical societies, and occasionally only one or two, are now performing this particular kind of an activity. There are areas in which medical associations can extend their advisory service into activities already known and found necessary.

Selected prophecies

For an unknown future, however, we must appreciate certain factors that even the experts can only guess at. In a symposium on the future, ten physicians looked at the future, a few of whom I should like to quote¹

Captain Normal L. Barr, (MC) USN, states:

Past experience gives us confidence that diseases, one by one, will be brought under control. We look forward to a Utopian time when surgery will be required only for the correction of malformations and the repair of trauma, when heart disease and cancer will fall to the bottom of the 'causes of death' list.

But as we can expect a reaction for every action in the physical sense, we must expect a reaction for these advances. Removal of the causes of death removes also the mechanisms that nature uses to control the world population. We are faced with a world population that will double at least each 50 years and lead to the horrors of super saturation. The eventual alternatives appear to be population control or the natural development of other automatic selection processes. The physician holds the primary concern, knowledge and responsibility in this difficult area and it will occupy more and more of his time and attention.

Associated with this concept of population explosion is the point of view of William B. Bean, M.D., who heads the Department of Internal Medicine of the University of Iowa College of Medicine. He says that

in seeking the Utopia of things we have forgotten values. Education in schools cannot make up for its deficiency at home but should

aim to inculcate a yearning for excellence, a desire for sound knowledge, a discipline which recognizes the necessity for hard work instead of the deadening short cut, the sense of personal responsibility and love of our fellow man, not the vague love of mankind. A return to drill in fundamentals, for the very gifted, and study of the needs and limitations of the retarded, should send to medical schools students prepared to cope with the rising tides of facts necessary to practice medicine at once humane and scientific.

He later points out that "The physician of tomorrow must employ the marvels of a busy and tireless science for he may not escape blame for negligence if he permits suffering or death because of ignorance. Unless we guide the next generation to improve upon our own, the passage of time will not mean progress."

In the same symposium, F. J. L. Blasingame, M.D., Executive Vice President of the American Medical Association, stated:

We must develop effective systems of disciplining unethical physicians and restraining those whose actions are damaging to the entire medical profession.

Casting its shadow in the years ahead is the threat of government domination. Our job is to prove to the American people and Congress that we and our allies are capable of conducting a program that is meeting, or can be expected to meet, the health needs of the people.

These three opinions—one looking to an enormous change in population, a second pleading for improved education that will produce better physicians, and the third pointing out problems that these physicians are likely to face in regard to their patterns of practice suggest some future difficulties related to the school health program.

For example, the population experts tell us that by far the greater portion of the population of the United States will be living in urban centers—in fact, in great metropolitan areas. What we now know as rural America will be rapidly depopulated. At one time cities were breeding places of disease and the country was looked upon as the seat of health. Now it is the city that provides for health service, the ongoing programs of prevention, and the better oriented educational programs that will help a younger generation live effectively

and efficiently. Living in cities, however, will require an increasing sophistication which comes only from an extension of education and a willingness to accept the responsibilities of group living.

At the last meeting of the Joint Committee on Health Problems in Education of the N.E.A. and A.M.A., an educator, Kenneth E. Oberholtzer, Ph.D., and a public health physician, Granville Larimore, M.D., attempted to look into this same crystal ball as a guide to the thinking of the Joint Committee on health problems of concern to the Committee's program. Dr. Oberholtzer pointed out that health education was a shared responsibility of the schools, and not a primary responsibility. This, however, does not lessen its importance, but puts it in a somewhat different context from other subject matter in the school curriculum. The timing of health education is extremely important. Every opportunity should be seized to make use of such factors as teachable moments, curiosity, and individual differences. But Dr. Oberholtzer points out that this is a an educational program for parents as well as for children. It starts in the pre-school period. The parent teaches the child and continues to teach him throughout life. Health behavior is almost exclusively a product of our culture.

Dr. Larimore pointed out the close relation between mental health and some of the new developments in psychiatry, in drug therapy, and in the recognition and handling of such problems as alcoholism and narcotic addiction. These new concepts have changed the management of patients both outside and inside hospitals, and emphasize the role of mental health in the community. The new discoveries regarding the relationship of viruses to cancer may reveal leads to the cause of some tumor formation. Communicable diseases are still of concern in education because the child is more frequently involved. A breakthrough leading to the prevention of such viral diseases as measles and chicken pox similar to the recent discovery of control methods for poliomyelitis may be imminent. Environmental health problems, particularly air pollution and radiologic hazards, are

on the increase. We need to know more about nutrients and their effect upon the body in order to have a better nourished population in the future. Chronic diseases bring such problems as rehabilitation and the financing of medical care, which are particularly important in a society where the dependency of both young and old is considerably longer than at any time in history. Medical care is in a process of change and can be expected to undergo further changes in the future, with continued growth of the insurance concept which allows people to share the cost of medical care.

Factual memory without understanding is one of the difficulties of health education. Because counseling and guidance in health are extremely important, we should look with favor upon school nurses who work as school counselors and guidance personnel with families and physicians. There is a great need for more guidance from physicians concerning nutrition, ways of living, the preparation of food, air pollution, gadgets, automation, and the nature of exercise. All of these are increasing in importance with our expanding population. Their relationship to health is a real problem.

Recommendations of the White House Conference

The reports coming from the recent White House Conference on Children and Youth suggest areas that should concern us as administrators of school health activities. Among these are the environment of the school, community coordination to provide more effective service, recognition of the family as the basic unit of our society, and the promotion of this concept through family life courses which prepare for marriage and parenthood. The curriculum should provide opportunities for the student to develop an understanding of the basic elements of health protection and an appreciation of physical education. Special educational services, pupil personnel services, leisure activities, and community programs are all a necessary part of this picture. A careful study of the report of

the White House Conference on Children and Youth will suggest many program areas in which local support will accelerate implementation. Working with the local committees to implement recommendations of the White House Conference should do much to strengthen existing programs for the protection of the health of children.

Conclusion

Looking to the future, we can be sure that there will be a change. There is every reason to believe that much that is now orthodox will gradually come to be regarded

as superstition, as a new orthodoxy develops out of present heresy and becomes the accepted standard for program planning. We must make every effort to understand what our colleagues of other professions are talking and thinking about when we meet together in the interest of these children and schools. And last but not least, we should use every opportunity to promote sound school health activities which express the best in both medicine and education.

Reference

1. Ten Looks At The Future, G.P. 19: 135-146 (Jan.) 1959.

Carcinoma of the Penis

W. C. MEBANE, M.D.

WILMINGTON

Although the last two decades have produced a vast amount of literature on malignancy, relatively few papers on cancer of the penis have appeared. In this country, where hygienic practices are meticulous, the incidence is comparatively low. Nevertheless, the disease remains an unpopular one for the surgeon as well as for the victim.

The disease differs from most forms of malignancy, for it is preventable and in many cases curable. This is to say that circumcision in infancy renders complete immunity for life. Circumcision in childhood, followed by good hygiene, provides almost complete immunity. The smegma bacillus growing under a long, moist foreskin poses a strong carcinogenic agent in a fertile soil, yet the public health authorities have had little to say on the prevention of this preventable and mutilating disease.

Cancer of the penis lends itself well to surgical therapy and to radiation. It is well situated for surgical attack. It is an external growth, can be recognized early, and involves an organ which is not essential to life or to urinary comfort. All or any part of the penis may be removed without loss of or serious effect on urinary control. If the lesion is discovered early, sexual function may be impaired but not completely lost. Even in advanced cases, the surgical

outlook is good, because the localization of lymphatic drainage makes block dissection feasible in most cases. The femoral, inguinal, and part of the hypogastric glands are readily dissected and removed along with the shaft of the penis.

Technique

It is our practice to amputate the corpora cavernosa 2 cm. proximal to the lesion. The urethra, surrounded by the corpus spongiosum, is dissected free and brought out on the skin of the perineum or scrotum. When the growth involves the entire shaft and a portion of the skin and anterior surface of the scrotum, the scrotum is divided in half, the corpora are completely removed from the ramus of the pubis, and the involved skin is resected. A perineal meatus is established. The scrotum is then reconstructed by suture. If part of the shaft can be left, it is well not to ligate the dorsal arteries and veins of the penis. The inguinal flaps frequently slough when extensive ligation is done. If the skin flaps on the penis or inguinal region slough, they can be easily covered by grafts.

An ample length of urethra is cut and is split into two strips 1 cm. long. These flaps are sutured to the skin with 000 silk to prevent retraction and stenosis. Use of a

Table 1
Operative Results in Ten Cases of
Cancer of the Penis
1944 - 1960

Case	Age (Years)	Results	Survival (Years)
1.	40	Living and well	16
2.	70	Died two weeks after biopsy	
3.	55	Living and well	12
4.	67	Living and well	9
5.	65	Living and well	9
6.	53	Living and well	8
7.	42	Died in 1953 with pneumonia	1
8.	69	Living and well	6
9.	68	Died in 1960 with coronary occlusion	6
10.	22	Living and well	1½

Foley catheter for five days protects the wound from urine. Urinary control is good when the catheter is removed.

Case Reports

Case 1

The patient, a 40 year old Negro man, was admitted on August 3, 1944, because of a large cauliflower growth, very foul, involving the entire glans penis. The growth, which he had had for six months, was about the size of a lemon, and had completely destroyed the glans penis and half of the shaft. The inguinal glands were enlarged and firm. A complete amputation of all the penis and resection of the groins was done in August, 1944. Two of the five lymph nodes from the inguinal region showed carcinoma. The patient appears well today, with a well functioning urethra, 16 years after his operation.

Case 2

A 70 year old Negro man was admitted on August 4, 1955, having had a growth on the penis since June, 1934. A biopsy was done, but the patient died shortly afterward with general malnutrition and chronic anemia. No definitive surgery was performed.

Case 3

A Negro man, aged 55, noticed a growth on the penis in March, 1946, and came to the hospital for treatment on March 28, 1947. The inguinal glands were enlarged. The primary growth was large and fungating, and had destroyed the glans penis, including the entire shaft, back to the edge of the scrotum. A biopsy was done, followed by amputation of the entire penis. The urethra was brought out on the posterior surface

of the scrotum. The patient was discharged on April 24, 1948. On December 12 he came back with a recurrence of the growth. By this time the tumor had spread to the skin of the scrotum and laterally to the skin of the perineum and adjacent thigh. The inguinal glands were enlarged on both sides. Another resection of the inguinal glands was carried out. The entire mass, including the scrotum and some of the skin of the perineum and testicles, was removed in one block. The urethra was brought out just anterior to the rectum and perineum. The patient returned on February 9, 1949, presenting an ulceration of the inguinal glands on both sides. These glands were resected, but showed chronic adenitis and cellulitis rather than carcinoma. The disease was far advanced, and arrest was not anticipated. On January 4, 1960, however, the patient was found to be well, with no evidence of recurrence. This case represents control of far advanced cancer for 12 years.

Case 4

A 67 year old white man, first noticed a growth on the glans penis in July, 1951. He came in for treatment in December, 1951. Examination disclosed a hard, disfiguring growth which had displaced and distorted the glans penis. The inguinal glands were enlarged. A radical amputation was carried out, removing the entire shaft of the penis and bringing out the corpus spongiosum with the urethra on the perineum at the most dependent portion of the scrotum. The inguinal glands were resected. There was some sloughing at the edges of the skin flaps, but this healed by granulation. The diagnosis was grade T squamous-cell carcinoma. The patient received a therapeutic dose of x-ray to the inguinal areas. He has remained well and has good urinary function at the present time. There is no evidence of recurrence. This case represents an arrest, and perhaps cure, of nine years.

Case 5

A white man, aged 65, was admitted in August, 1951 with a hard indurated growth on the glans penis near the corona, and with enlarged inguinal glands bilaterally, of one year's duration. A histologic examination of tissue showed squamous-cell carcinoma. The penis was amputated at the level of the symphysis pubis. The corpora cavernosa were closed and the skin was closed over the corpora. The corpus spongiosum was first sutured to the end of the penis, but was amputated a little too short and retracted. This resulted in fibrous constriction of the meatus. About six weeks later the urethra was transplanted to the perineum behind the scrotum. The patient had no further urinary difficulty. Both the inguinal and femoral glands were resected on

both sides. The patient has remained well until the present time, representing control of this carcinoma for nine years.

Case 6

A 53 year old white man had an ulceration under the foreskin involving about 1 cm. of the corona of the glans penis. Histologic examination after biopsy showed squamous-cell carcinoma, grade II. The inguinal glands were not enlarged. The foreskin together with the lesion was resected locally, leaving a margin of about 2 cm. around the ulcer. The skin of the shaft was used to cover the defect in the glans. The inguinal glands received x-ray therapy. Surgery and irradiation effected a cure or control for six years. The organ functions well.

Case 7

A 52 year old Negro man was admitted to the hospital on August 9, 1952, because of a growth on the penis of nine months' duration. Following biopsy, a partial resection of the penis and inguinal glands was performed, retaining about half of the shaft of the penis. The inguinal glands were reported to show chronic inflammation rather than carcinoma. This patient died about one year later with bronchopneumonia and septicemia following peritonsillar abscess. There was no external evidence of recurring carcinoma.

Case 8

A Negro man, aged 59, first noticed a growth on the end of the penis in January, 1953. The lesion was locally excised in March, 1953, but continued to ulcerate. In one year the distal half of the penis was destroyed. The inguinal glands were hard and indurated. In January, 1954, a complete amputation of the penis and resection of the inguinal glands were carried out. The urethra was transplanted to the perineum, and the entire shaft of the penis was removed. The diagnosis was grade I epidermoid carcinoma. The patient is well and working today, with no signs of recurrence. This case has been controlled for six years.

Case 9

The patient was a white man, aged 68 years and very obese. He was admitted in November, 1954, with a tumor of the penis under a tight foreskin. According to the patient, the growth had been present for about three years. There was extensive ulceration and inflammation involving the foreskin. The inguinal glands were enlarged bilaterally. The shaft of the penis was not involved, and the distal one-third of the glans penis was resected. The urethra was

brought out on the skin of the scrotum. The inguinal and femoral glands on both sides were resected. The pathologist reported squamous-cell carcinoma of the penis and inguinal glands.

The patient was readmitted in September, 1956, after having been well for approximately two years. The penis and inguinal glands appeared normal, but there was a lesion on the inner side of the left thigh which proved to be malignant ulceration. This lesion was excised extensively and a split-thickness skin graft applied. Following this procedure the patient remained well until his death from a coronary occlusion in June, 1960. His case represents a far advanced carcinoma of the penis which remained arrested and possibly cured for a period of six years.

Case 10

A 22 year old white married man was admitted to the hospital in July, 1959. For one month he had noted a sore nodule under a tight foreskin. He was unable to retract the foreskin and maintain hygiene. No enlargement of the inguinal glands was noted. Histologic examination disclosed grade II squamous-cell carcinoma. The patient reluctantly agreed to an operation and requested that we save as much of the penis as possible. The lesion was resected 2 cm. proximal to the corona. The corpora were closed with fine catgut. The urethra extended 0.5 cm. beyond the shaft, and a graft was used to cover the end of the shaft. The inguinal glands were resected, but were found to be free of tumor. The patient's recovery was uneventful. A follow-up examination in September, 1960, 18 months after operation, showed no recurrence of the growth, and urinary function was good. The patient states that sexual function is quite satisfactory.

Summary

Cancer of the penis is preventable, and should receive more attention in preventive medical programs. The lesion is nearly always a squamous-cell tumor which begins around the corona. It tends to metastasize slowly to the inguinal and femoral glands, but very rarely by the blood stream. It is highly amenable to surgical treatment and to some degree to radiation.

Ten illustrative cases are reported, 5 in Negro and five in white patients. These cases are reportedly consecutively as they were encountered in the course of a general surgical practice during the years 1944 to 1960.

Neck Injuries in Children

H. FRANK FORSYTH, M.D.

WINSTON-SALEM

The remarkable thing about neck injuries in children is their relative infrequency. Compared to the amount of violence to which it is subjected, this portion of the anatomy of the infant or growing child is rarely the site of significant damage. Consider the falls, the gymnastics, the wrestling, the rough games and contact sports, as well as automobile and other vehicle accidents in which most children are involved as they grow up, and it becomes a miracle that more of them are not paralyzed by the time they reach adulthood. One would have to conclude that the limber cervical spine of the child is so well constructed and reinforced with ligaments that it is able to resist most of this trauma; or else that our roentgenographic and other diagnostic measures are not adequate to show us the effects of the trauma in spines that are composed, to a fairly large degree, of cartilage. Interpretation of roentgenograms of the cervical spine is difficult enough in the adult because of superimposed bony structures, but in the child it is still more confusing. We must be aware of the presence of epiphyseal lines, and the unossified portions of the skeleton, and also become more familiar with the normal appearance of the spine at the different age levels.

Clinical Material

During the past 12 years we have treated 175 patients with serious injury of the cervical spine at the North Carolina Baptist Hospital. Only 10 of the patients in this group were under 15 years of age, thus placing them within the pediatric age limit. These 10 patients varied in age from 8 months to 12 years, with a mean age of 6 years. The sex distribution was equal. It is

worth noting that the incidence rises sharply in the 15 to 25 year group, owing to the large number of severe automobile accidents and the preponderance of diving injuries within this age range.

In the childhood group (table 1) we found that 4 out of 10 patients had atlanto-axial dislocations due to tearing of the transverse ligament of the atlas. In 7 of the 10 patients in this group the injury occurred in the upper 3 cervical vertebrae. The remaining 3 patients suffered injuries of the lower cervical region: A bullet wound of the sixth cervical vertebra caused the injury in one patient, who was paralyzed but recovered. Posterior dislocation of the seventh cervical vertebra occurred in the other 2 children who were struck by automobiles. Both victims were tetraplegic, and the complications resulted in death in one case, and permanent paralysis in the other.

Not included in this group of serious injuries, but still of considerable interest under the general topic of neck injuries, is a group of 14 patients who had simple rotary subluxation of the cervical spine (table 2). There was an even distribution of ages in this group from 2 years up to 16 years, but 10 of these children were boys while only 4 were girls. No cases of this entity were seen beyond the age of 16 years, although the condition has been known to occur in young adults. The clinical picture is a familiar one which is usually caused by relatively minor trauma such as a sudden twisting of the neck or a fall on the side of the head. In most instances it seems to occur during an unguarded moment when the muscles which would ordinarily prevent it are relaxed. In 3 of these cases the patients brought on their own disability by a sudden jerk of the head during a fit of anger. Much to their surprise, there was a momentary sharp pain, and the head would not return to its starting point.

The typical deformity is a torticollis

Read before the Section on Orthopaedics and Traumatology, Medical Society of the State of North Carolina, Raleigh, May 11, 1960.

From the Section of Orthopaedic Surgery, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina.

Table 1
Serious Cervical Spine Injuries In Children

Cases	Date	Sex	Age	Lesion	Cause	Treatment	Result
1.	1959	M	7	Partial atlanto-axial dislocation; tear of transverse ligament of atlas	Struck by auto	Bedrest, cervical collar 3 months	Normal neck
2.	3/10/59	F	5	Unilateral atlanto-axial dislocation; partial tear transverse ligament of atlas	Fell on head from chair	Traction Minerva cast 3 months	Full recovery
3.	9/29/57	M	4	Atlanto-axial dislocation; partial tear transverse ligament of atlas; cerebral contusion	Struck by auto	Traction; spinal fusion C1-2	Stable neck; good result
4.	1957	M	12	Severe hyperextension with posterior dislocation C7 on T1; transection of cord	Struck by truck while riding bicycle	Traction; laminectomy, etc.	Tetraplegia; permanent confinement to wheelchair
5.	8/27/56	M	6	Anterior subluxation C2 on C3	Diving over arm of sofa. Struck on top of head	Traction cervical collar	Full recovery
6.	3/16/56	F	11	Partial atlanto-axial dislocation; partial tear transverse ligament of atlas; head injury	Struck by auto	Bedrest; traction cervical collar	Good function; slight residual displacement
7.	12/5/51	F	6	Subluxation C2 on C3	Fell on head from porch	Minerva cast 2 months	Complete recovery
8.	7/7/51	F	18 mon.	Slight anterior fracture dislocation C3-C4	Fell down steps on head	Bedrest; cervical collar	Normal function
9.	7/7/51	F	8 mon.	Head injury; posterior dislocation C7 on T1; paraplegia	Auto accident	Bed rest; traction	Death in 5 days
10.	7/14/49	M	9	Fracture body of C6; Brown-Sequard syndrome	Gunshot wound	Skull traction Minerva cast	Complete neurologic recovery

Table 2
Rotary Subluxation of Cervical Spine
(Clinical Cases)

Cases	Sex	Age	Cause	Treatment
1.	Male	7	Sudden twist	Traction for 2 days
2.	Male	12	Sudden twist	Manipulation
3.	Male	9	Fell turning somersault	Manipulation
4.	Female	4	Sudden twist	Head halter traction 2 days and then manipulation under anesthesia; adhesive strapping 2 days
5.	Female	2	Fell from bed	Manipulation
6.	Male	16	Twisted head while wrestling.	Manipulation
7.	Male	3	Fell in bathtub	Traction 3 days (Manipulation failed)
8.	Male	8	Fell in swimming pool	Traction 2 days (Manipulation failed)
9.	Male	14	Fell while tumbling	Traction 3 days
10.	Male	8	Fell in swimming pool	Traction 1 day
11.	Male	16	Fell while tumbling	Manipulation
12.	Female	15	Twisted head looking in mirror	Traction 2 days
13.	Male	6	Slapped in face and jerked head back	Manipulation and cervical collar 2 days
14.	Female	5	Fell on head	Traction 2 days

with the head rotated to one side about 20 or 30 degrees. The chin is tilted upward toward that side, but the head is inclined toward the opposite side. The pain, tenderness, and muscle spasm are in the posterior neck muscles on the side toward which the face is turned. The sternocleidomastoid muscle on the opposite side is relaxed, in contrast to the usual findings in acute cervical myositis or the spastic or congenital types of torticollis. There is a limited degree of mobility, but the head always returns to the same inclined position. There is no neurologic deficit, and I am not aware of any danger that one will develop. It is characteristic of this lesion that it is easily corrected by manipulation or the application of halter traction to the head for a day or

two. I have not found it necessary to apply any type of holding device after reduction, and there has been no instance of recurrence. Any residual muscle soreness has cleared up within 24 to 48 hours.

One of our patients had the "non-traumatic" or "hyperemic atlanto-axial dislocation" with relaxation or dissolution of the transverse ligament of the atlas thought to follow tonsillitis or pharyngitis. She was a 6 year old girl who fell in the yard from an insignificant slip a week after having an upper respiratory infection. The next morning she had a wry neck associated with pain in the upper cervical spine. Roentgenograms showed a mild rotary anterior dislocation of the atlas on the axis. Reduction was accomplished with ease by

skull traction and maintained for two months by means of a Minerva Jacket. After that her neck had normal function, and appeared normal by roentgenogram, including lateral views in flexion and extension.

One sees numerous instances of an acute type of torticollis, which is also frequently associated with an upper respiratory or other infection about the head. It appears to be an acute myositis, and is characterized by spasm of the sternocleidomastoid muscle and tender, deep cervical adenitis. There is no pain, spasm, or tenderness posteriorly over the spine or erector spinae muscles, and it is not actually a condition related to the spine itself.

Other conditions of importance in the differential diagnosis of cervical spine injuries are some of the congenital anomalies that may involve this area. These would include congenital absence of the odontoid; failure of fusion of the dens and the body of the axis; occipitalization of the atlas, platybasia, basilar invagination or other abnormalities of the foramen magnum; and the various types and degrees of Klippel-Feil syndrome. In the presence of some of these lesions which tend to make the neck weaker structurally, such as absence or failure of fusion of the odontoid, or to make the spinal canal smaller such as basilar invagination and other anomalies of the foramen magnum, a relatively minor injury of the neck could result in serious compression of the spinal cord. It would take a high index of suspicion for one to be aware of such a possibility and make the diagnosis in the face of a history of minimal trauma. On the other hand, if one were to see roentgen evidence of Klippel-Feil syndrome in films of a cervical spine made sometime after a minor injury, he might think that the trauma had been of much greater magnitude than it actually was. Such an error in understanding might lead to overtreatment as far as a patient was concerned, or to overpayment in case an insurance settlement was due.

Summary

A brief review of the cervical spine

injuries in children treated at the North Carolina Baptist Hospital during the past 12 years indicates that serious damage occurs infrequently in children as compared with the same injuries in adults. It also points out that the upper three cervical vertebrae were much more frequently involved than the lower ones, and in general there was a greater tendency to dislocation than to fracture.

Congenital anomalies were mentioned as a possible complicating factor in injury as well as an important factor to be remembered in roentgen diagnosis and treatment.

Report from The Duke University Poison Control Center

J. M. ARENA, *Director*

LEAD POISONING

PART III

Treatment

If the poison has been recently ingested, wash the stomach with warm water or a 1 per cent sodium sulfate solution. A saline cathartic, such as 30 Gm. (1 ounce) of magnesium sulfate, should be given to flush the lead from the intestinal tract and reduce absorption. Egg white, milk, or other demulcents are useful for soothing the irritated gastric mucosa.

To control colic, calcium gluconate 1 Gm. (15 grains) is given intravenously and repeated as necessary to obtain relief. Morphine sulfate, 15 to 39 mg. (1/4 to 1/2 grain), should be given hypodermically as necessary for control of severe pain. Maximum dosage for children is 1 mg. per 10 pounds of body weight.

The most effective method of removing lead is the intravenous administration of solution calcium disodium versenate, which is superior to BAL as a de-leading agent in that it has a higher therapeutic to toxic ratio and a high coefficient of chelation for lead. This drug should be given by in-

travenous infusion only, and the concentration should not exceed 3 per cent. One ampule, 5 ml. of a 20 per cent solution, must be diluted to at least 33 ml. The following procedure is recommended:

Dilute the 5 ml. (1 Gm.) from an ampule with 250 to 500 ml. of solution isotonic sodium chloride, U.S.P., or sterile solution of 5 per cent dextrose suitable for intravenous injection. Administer this diluted solution by intravenous drip over a period of one hour. This dose may be administered twice daily for periods up to five days. If additional treatment is indicated, a two-day rest is recommended, to be followed by another five-day course.

The dose for children should not exceed 0.5 Gm. per 30 pounds of body weight, administered as above. Intermittent intramuscular injections of a 20 per cent solution containing 0.5 per cent procaine in a total daily dosage range of 50-75 mg. per body weight for five to seven days is also effective.

Versonate makes available for the first time reasonably safe, effective therapy in heavy metal poisoning without organ injury during excretion.

Solution calcium disodium versenate is the calcium chelate of ethylenediaminetetracetic acid (EDTA). (In the body calcium is displayed by lead, forming the lead chelate—nonionized, nontoxic, water-soluble, nonmetabolized, and excreted intact.) This compound cannot produce exacerbation of symptoms during period of therapy. It is potentially nephrotoxic and overdosage or prolonged treatment can cause nephrosis, which usually clears promptly after therapy is discontinued.

Oral administration of EDT is not as satisfactory as parenteral administration, and may even be harmful. If excessive quantities of lead are present in the gastrointestinal tract, the resultant chelated lead is well absorbed, and while most of it may be excreted in the urine, there is always the possibility that total stores of body lead may be increased. The prophylactic oral use of this drug in lead workers should

never replace proven preventive and protective measures.

In lead encephalopathy with status epilepticus or coma, restricted parenteral fluids and parenteral EDTA are mainstays of therapy, with parenteral anticonvulsants and intensive supporting care including drugs (urea, etc.) for diminishing the increased intracranial pressure. Extensive craniectomy with opening of the dura appears to have saved lives and to have prevented, in some instances, irreversible brain damage.

Lead Arsenate and Arsenite

These compounds are white, heavy powders which are extensively used as insecticides. Intoxication may arise from inhalation of the powder during spraying operations and from the ingestion of contaminated drinking water or food. The clinical picture of lead arsenate poisoning more closely resembles that of lead than of arsenic poisoning, although certain symptoms occasionally are similar to those produced by arsenic. Nevertheless, toxicity is mainly due to the lead component and treatment is essentially the same as that of lead poisoning. BAL, however, might be more useful than EDTA, since both lead and arsenic may be responsible for the presenting symptoms.

Lead, Tetraethyl

This highly toxic compound is an oily liquid which is added in small amounts (1:1000) to gasoline to lessen "knock" by preventing premature combustion. Poisoning arises directly from contact with tetraethyl lead itself, which is absorbed both from the intact skin and lungs. The toxic effect is due to the triethyl lead formed during the breakdown of the tetraethyl compound, which causes inflammatory and degenerative lesions in the brain and other tissues. Acute central nervous system excitement results, with delirium and mania. The main risk of this type of poisoning exists in industrial workers, but present precautions and prophylactic measures are adequate in eliminating these dangers.

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MARCH, 1961

EXECUTIVE COUNCIL MEETING

The midwinter meeting of the Executive Council of the State Medical Society was held in Pinehurst on February 12—the day after the Conference of County Medical Society Officers and Committeemen. Both meetings had been postponed for two weeks on the advice of the Highway Commission because weather conditions made driving hazardous. One could not have asked for better weather at this meeting, however, and the meeting was well attended.

Since a called meeting of the House of Delegates will be held in Durham on February 26, to ratify the most important actions of the Council, this account of the highlights of the Council Meeting is in the nature of a preliminary report.

Most of the morning session was devoted

to the stand the Medical Society should take in the Medical Assistance for the Aged Program proposed by the Kerr-Mills Act. After much discussion pro and con, a motion was made that the Society would not ask for vendor payments at this time. It was brought out in the discussion that not more than 65,000 people past 65 were apt to apply for medical assistance under the Act, and of these not more than 10,000 or 15,000 per year would apply. Mr. J. W. Foristel of the A.M.A. Washington Office said that it would be a good policy from the public relations viewpoint not to ask for vendor payments for the present. He also said that North Carolina was one of the four key states to encourage participation in the Kerr-Mills Act instead of the Social Security approach—and that unless at least 24 states adopted the Kerr-Mills Programs by the end of this Congress we would be "in bad shape."

A motion to rescind the November meeting action of the Executive Council and decline to ask for vendor payments was passed by a vote of 13 to 4.

Dr. Roscoe McMillan, chairman of the Committee on Constitution and By-Laws, called attention to Article IV, Section 6, of the Constitution, which states: "Life Members shall consist of those physicians who have been members of the Society consecutively for 20 years and who have attained the age of 70 years. They shall be exempt from all dues and assessments and shall be entitled to all the privileges enjoyed by active members in good standing except the privilege of holding office and receiving the JOURNAL." He asked that the Council recommend that the phrase, "except the privilege of holding office and receiving the JOURNAL," be deleted. This motion was passed unanimously.

Dr. McMillan also paid a tribute to the Auxiliary, and asked that if they requested it, a sum not to exceed \$600 per year should be granted the Auxiliary for employing part-time secretarial help. This was unanimously approved.

Dr. Everett Bugg's *ad hoc* Committee on Relative Value Scale Study submitted copies of the report prepared by his com-

mittee. A motion was passed that the Relative Value Scale Report be approved in principle and that the committee be continued, with authority to change the Relative Value Scale after negotiating with groups involved. The comment was made that a foreword of explanation was needed.

Dr. Wayne Benton, chairman of the Committee on Finance, reported that the Society was "financially well off" and that our investments were returning a satisfactory yield. He also said that by 1963 Greensboro would have ample hotel and coliseum facilities to entertain the Society, and requested that the Nominating Committee bear Greensboro in mind as a possible meeting place for 1963.

A gratifying announcement was that our Society's membership now entitles it to a fourth delegate to the A.M.A. Dr. Amos Johnson was unanimously elected as delegate and Dr. George Paschal as alternate to serve through next December.

Before adjourning, the Council voted to authorize a called meeting of the House of Delegates to be held in Durham on February 26 at the Jack Tar Hotel beginning at 10:00 A.M. This is an important meeting of the House and it is hoped that there will be full attendance.

* * *

THE WHITE HOUSE CONFERENCE ON AGING

Dr. Amos Johnson's "President's Message" in last month's issue gave an excellent account of the White House Conference on Aging. The Conference was important enough, however, for some further editorial comment.

When the newspapers announced during the Conference that seven work-groups had voted in favor of the Social Security approach to old-age assistance, most readers assumed that the overwhelming majority of the delegates favored that method over the present Kerr-Mills plan. The statement was misleading—whether intentionally or not. There were 2,800 delegates, divided into 10 groups, 20 sections, and 140 work-groups. Section 2 of group 1, dealing with income maintenance, was broken up into seven

workgroups with a total of 285 members. This section was the only one allowed to vote on the method of financing medical care for the aged. An astute observer of the political scene, Dr. Marjorie Shearon, in the January 19 issue of her *Challenge to Socialism*, tells how cleverly long-time advocates of federally controlled medicine had planned the conference. The important section 2 with its seven workgroups was dominated by hand-picked advocates of Social Security. Even so, the combined vote of the seven sections was only 96 to 77 in favor of the Forand type of legislation—a majority of only 19.

In contrast, the section on health maintenance voted 165 to 122 in favor of an amendment stating that "Existing federal-state matching programs will provide effective, economical, dignified medical care for our elderly citizens who need help. The implementation of such programs should result in the high quality of medical care desired. Compulsory health care inevitably results in poor quality health care." For some reason the newspapers gave scant or no mention to this vote—although it should more than counterbalance the vote of section 2.

Dr. Shearon noted that the workgroup discussing the financing of medical care costs "had no representation from the medical profession which would have to furnish the medical care" . . . and the commercial insurance companies, Blue Cross-Blue Shield, and other interested groups were not adequately represented. Instead were seen "Representatives of organized labor, social workers, Federal employees from the H.E.W. Department, two commercial insurance officials, one representative of Blue Cross, the President of the American Nurses' Association, which is on record as favoring compulsory health insurance, a Public Health physician, and a physician from a Welfare Department." Dr. Shearon replied to the charge made by Professor Wilbur J. Cohen on January 5 that the White House Conference had been stacked by A.M.A. by saying, "We do agree that at least one section was stacked. Not by the American Medical Association, but

by the proponents of national health insurance who are seeking to put over a national scheme of Federal medicine for the aged, using the social insurance mechanism."

Two excerpts from the A.M.A.'s *Medical Legislative Digest* for January 24 are pertinent: "The Communist Party of Illinois has recently distributed a brochure entitled 'The Forand Bill Can Be Won Now!' This brochure, under the subtitle 'The Forand Bill is the Minimum, indicates the future aims of the Illinois Communists: 'The virtue of the Forand Bill is that it is a Federal, rather than a State-aid measure, and is built into the Social Security system. With all its present limitations the Forand Bill opens the door toward complete hospital, medical and surgical services for the aged, and ultimately for the whole population. It can be enacted at once by this session of Congress.'

"The December 1, 1960 supplement to 'New America', the official publication of the Socialist Party, is devoted to the support of the Forand bill and its extension to every one in the United States. This publication says in part, 'Once the Forand bill is passed this nation will be provided with a mechanism for socialized medicine, capable of indefinite expansion in every direction until it includes the entire population. And it is already evident that there will be massive pressures in favor of such expansion.' "

One encouraging development of the Conference was that almost every section went on record as opposing compulsory retirement at a fixed age.

A final thought is that our representatives had just cause to feel proud of North Carolina's record in caring for its older citizens. Our state is well in the vanguard in providing adequate care for the aged.

It remains to be seen what action Congress will take in its present session. Certainly the deliberations of the White House Conference did not give a mandate for the

Forand type of providing medical assistance through Social Security.

* * *

WESTBROOK'S GOLDEN ANNIVERSARY

The two news items in this month's "Bulletin Board" about Westbrook Sanatorium should be of particular interest to North Carolina doctors. Westbrook was founded by two North Carolina physicians—Dr. James K. Hall, of Statesville, and Dr. Paul B. Anderson, of Wilson. Dr. Hall's sister is the wife of North Carolina's Senator Sam Ervin. Dr. Hall died in 1948, but a son bearing his name is following in his distinguished father's footsteps.

Another reason why North Carolina doctors may feel a personal interest in Westbrook is that Dr. Saunders is also a North Carolinian. He was superintendent at the State Hospital in Morganton until he fell a victim to political intrigue. He has found his connection with Westbrook far more pleasant, as well as more profitable.

Congratulations and best wishes to Westbrook Sanatorium and its medical staff.

* * *

TRANSITION TROUBLE

The late appearance of the January issue of the *North Carolina Medical Journal* calls for some explanation. The editorial and scientific material was in the hands of the publishers in ample time to meet the requirements for earlier publication. In the transition from one publisher to another, however, there was considerable delay in receiving advertising material—so that the actual printing of the January issue was not begun until well after the first of the month.

Both the publisher and the editor concur in regretting the unfortunate start of Volume 2, but—barring unforeseen delays—hope and expect to make amends by having successive journals in the mail by the middle of each month.

At present, with the high cost of medical care a major social problem, it is imperative to avoid performing unnecessary and costly tests.—Levine, S. A.: Worry—Where Will It Get You? *The Pharos* 23: 215 (Oct.) 1960.

President's Message

LET'S WIN THIS BATTLE

Presently the people of America are more aware of and conversant with information and facts related to medical care than ever before. The forum of public opinion is in the process of communicating its decision to the legislative chambers of our Congress. It is fitting and proper and imperative that the full weight of the potential influence of each individual physician in this country reflect itself in the decision of this forum of public opinion in order that available high quality medical care may remain the heritage of all Americans.

The medical profession is more concerned than any one group with the health of the aged in particular and of all people in general—and can prove it. There are more aged people alive now because of increasingly good medical care during the past half century. Yet, it is apparent the medical profession gets little credit for a job well done. Why should social science educators, social workers, labor leaders, or politicians be recognized as the people most concerned with the health of the aged?

What are the motives of these people who have suddenly interjected themselves into the picture of medical care? Are they really concerned with the availability, quality, and cost of medical care? Do they really believe that "Uncle John" doesn't get to the doctor or hospital because he can't *afford* it? Or, are they concerned with utilizing this area of national sentiment as an approach to *altering the basic philosophy* of American Government?

These are the people who put Norman Thomas and the Socialist Party out of business in the United States. These are those who since the early thirties have, piecemeal, sold packages and packets of socialism to the people of this country to its ultimate socialization beyond the fondest dreams of ex-presidential Socialist candidate Thomas. These people would next have medical care for all a service and function of the Federal Government in their unswerving drive towards a total welfare state.

But all is not well with Medicine. Throughout the past three decades medical leadership in America has evidenced but little insight and astuteness in formulating policies. Medicine has participated in and, in fact, produced a scientific revolution within its own area which is equivalent to and partly productive of similar upheavals in the social, political, and economic aspects of American life. While fostering immense medical progress, as a profession, we have concurrently failed to participate in revolutionary social, political, and economic progress which is equally important in the total picture of the "American Way of Life." Medicine must re-evaluate its purposes and policies. We must supply America the products of American medical progress, which our people rightly demand, within the framework of long range policy and planning which is ultimately good for the American people. This should not be and will not be to the detriment of American medicine. By assuming the lead in this movement, Medicine can remain free; continued resistance insures captivity.

While proper and astute long range policy and planning is imperative to insure the survival of free organized medicine (A.M.A.), there is also need for astute impulsive leadership. Recently, at the White House Conference on Aging the American Medical Association was beautifully finessed. Much "face" was lost for American Medicine. More recently, Medicine has been maneuvered into participation in public debates, panels, and other programs on television, competing with experts, under the circumstance of an "atmosphere" of public opinion so hostile to medicine that for us to win was impossible. The timing was poor. So let's say, *touché*, and alter our approach to the problem at hand.

While the leadership and identity of the A.M.A. may necessarily be slow to change, state medical societies are more flexible and closer to the people they serve. A constructive effort here could generate much un-

derstanding and support for the medical profession and determine how best it can serve under free enterprise, rather than permit the Federal Government to interpose itself to the detriment of the quality, cost, and availability of medical care. Action from the community level upward in any national organization usually gets best results.

In due process then we should next evaluate our position as organized physicians in the framework of today's altered "American Way of Life." The profession of medicine, as indeed are other professions and social institutions, is the product of past eras. The interaction of certain prevalent forces—that is, communications, social, economic, political, etc.—each upon the other determines the product. The progress of time brings into play new forces and circumstances, yet the profession or institution resists change and stubbornly lives on as in the past. "It has a life of its own, apart from the life of society—and things that had once been recognized as the product of their time and place are spoken of as if by some decree they had been given eternal validity."* Is Medicine guilty, as charged, of an unawareness of certain recently recognized social phenomena which should alter, to some degree, the structure of the present "ground rules" for the provision of and payment for medical care? Would we best, as an organized profession, have a soul-searching evaluation of Medicine's position in present day society, and act accordingly? These are questions relating to problems of utmost importance to us as physicians. The summation of our individual informed opinions must answer these queries. Medicine must take the initiative and supply the leadership. Time is of the essence.

Once we are evaluated in our proper perspective and proper ideology is established, the battle to remain a free profession must be won from the community level upward. Just as government derives its authority to

rule by consent of the people, either expressed positively or by default, so ultimately will state medicine stand or fall by the will of the people, expressed either positively or by default. Although we know that the propaganda calculated to perpetrate this monstrosity upon the American people is fostered by socialists in high places and is disseminated and supported by "party-line politicians" from the top down, we can not win this battle using similar strategy. Labor, social scientists, social workers, and politicians welcome and encourage top level debates and panels with Medicine, and in the present atmosphere of public opinion we lose every time. We must complete the cycle by impressing on every individual American, who is each ultimately the patient of some physician, the truth and importance of the principles at stake. This opinion then must arrive, as a positive statement, either individually or collectively expressed, to our legislators in Washington.

This essential accomplishment we, as physicians, can not buy. In this endeavor we will either succeed or fail by the degree to which we are willing to give of ourselves. Is the prospect of Medicine's survival as a free enterprise profession within the motivation of that which is good for the American people worth a few minutes of your time an effort each day?

Our obvious need for better understanding is for every practicing physician to devote some portion of his time to act as a spokesman for what is best in Medicine. By wise participation in community or state activities you can demonstrate by *deeds and words* what modern Medicine under free enterprise can accomplish for all. In other words, if each doctor will contribute his own good character and talents to help create a better understanding of American Medicine, *what changes* could be wrought in the problem facing this same American Medicine. THIS INVOLVES YOU.

AMOS N. JOHNSON, M.D.
PRESIDENT

*August Heckscher: Medicine and Society.

Correspondence

NORTH CAROLINA BIENNIAL REGISTRATION ACT

To the Editor:

In July of 1960 you published a letter I wrote voicing my dissatisfaction with certain aspects of the North Carolina Biennial Registration Act.

Recently I have surveyed several southern states to ascertain their standing on a medical registration fee. Perhaps, the members of the State Society will be interested in this information. All of the states surveyed had registration in effect except one, South Carolina, and it expects biennial registration to begin in the year of 1961. The State of Maryland's registration fee is one dollar per year, but no charge for registration if not in practice; Tennessee's annual registration fee is five dollars; Alabama originally charged ten dollars but has recently reduced their registration fee to five dollars; Florida has an annual registration fee of one dollar; and Georgia charges a fee of three dollars annually.

To my knowledge the only general information given to the members of the North Carolina Medical Society relative to the basis for the Biennial Registration Act appeared in the guest editorial in the NORTH CAROLINA MEDICAL JOURNAL, December 1957. It said: "If the Board of Medical Examiners had not had definite plans for such an enactment, the Commission for Reorganization of the State Government would have forced us to come under such a regulation. A bill was enacted in the 1957 Legislature requiring the secretary of all boards to report to the Secretary of State the name and address of each licensee of the respective board. This could not have been done without registration." It was further stated in the editorial that a registration act was the only way that the Board of Medical Examiners could give the Secretary of State such information and thus necessitating this law. Still, however, we were not given the reasonableness for such a law.

The questioning of a five dollar registration fee is not of niggardliness but rather to

determine proper economy. It would appear to me that the fees (\$25,000.00 plus) collected are more than are necessary for this function. In a statement in the August 1960 NORTH CAROLINA MEDICAL JOURNAL it is stated: "Registration is not put into effect as a revenue measure—." If this be true, then it would appear that two periods of registration would be ample to allow the Board of Medical Examiners to re-assess the situation and thereby determine whether the fee is proper as it stands in adequate time to report it to the Medical Society this year.

I think it is the responsibility of every member of the State Society to voice his opinion upon the pertinent matters that arise within it, I hope other members will do so.

J. R. GAMBLE, JR., M.D.
LINCOLNTON

MEDICAL CARE FOR THE AGED

To the Editor:

I listened to the telecast on CBS Thursday night (Feb. 2) on care for the aged. I wonder if you saw it. It certainly put the medical profession and the Blue Cross Commission in a sad light.

I was astounded that such a slanted biased program would be presented under the heading of public information. I am disturbed, too, about the lack of understanding of the real problems among many of our doctors.

I think that medicine is facing the graves crisis in its whole history. In my mind there is a question as to whether even our voluntary health insurance agencies will survive the next few years of the Kennedy administration.

We all know, of course, that Mr. Reuther has no sentimental ideas about the aged. His program calls for ultimate and total state medicine under the Social Security Administration.

If you think any of this could be used in the Medical Journal, you are welcome to use it. I think it is high time the other side was being presented.

V. K. HART, M. D.
CHARLOTTE

Bulletin Board

Preliminary Program of the ONE HUNDRED SEVENTH ANNUAL SESSION

The Medical Society of the
State of North Carolina

May 6, 7, 8, 9, 10, 1961

ASHEVILLE, NORTH CAROLINA

Headquarters

Battery Park and George Vanderbilt Hotels

SATURDAY, MAY 6, 1961

11:00 A.M.—Executive Council Meeting
(Business of this Session may be
continued Sunday morning at 10
o'clock)
(Battery Park—Grove Room)

SUNDAY, MAY 7, 1961

10:00 A.M.—General Registration opens, Booth
(Lower Hall—Asheville City Audi-
torium)
(Society members, Delegates, Offi-
cials, Guests, Technical and Scientific
Exhibitors will register in this Area)
(Auxiliary Members to register at
The Manor)

1:00 P.M.—Scientific and Technical Exhibits
open

2:00 P.M.—First Meeting of the Annual Meeting
THE HOUSE OF DELEGATES of
the Medical Society—Donald B.
Koonce, M.D., presiding
(Agenda will be available)
(Assembly Hall—Asheville City
Auditorium)
Invocation: (local minister to be an-
nounced)

6:00 P.M.—House of Delegates recesses to Mon-
day, May 8, 2:00 P.M.

8:00 P.M.—Memorial Service
Charles H. Pugh, M.D., Chairman,
presiding
Choral Presentation: (to be anounc-
ed)
Address: (to be announced)
(Battery Park—Gold Room)

MONDAY, MAY 8, 1961

8:45 A.M.—Scientific and Technical Exhibits
Open
(Asheville City Auditorium—Exhibit
Hall)

9:00 A.M.—General Registration opens, Booth
(Lower Hall—Asheville City Audi-
torium)
(Society Members, Delegates, Of-
ficials, Guests, Technical and Scien-
tific Exhibitors will register in this
area.)
(Auxiliary Members to register at
The Manor)

9:00 A.M.—NORTH CAROLINA BOARD OF
MEDICAL EXAMINERS
(Meet for Business and Hearings)
(Battery Park—Grove Room)

FIRST GENERAL SESSION

Monday, May 8, 1961

Asheville City Auditorium—Assembly Hall)
9:00 A.M.—Convene Session

Amos N. Johnson, M.D., President
9:10 A.M.—PYELONEPHRITIS
William H. Boyce, M.D., Professor of
Urology, Bowman Gray School of
Medicine, Winston-Salem

9:30 A.M.—HOSPITAL AND SURGICAL IN-
FECTION
Howard W. Steel, M.D., Department
of Orthopaedic Surgery, Temple
University Hospital, Philadelphia,
Pa.

10:00 A.M.—The Annual Address of the President
Amos N. Johnson, M.D., President
The Medical Society of the State of
North Carolina, Garland

10:30 A.M.—Break
11:00 A.M.—TRAUMA AND THE CONTAMIN-
ATED WOUND

Chalmers R. Carr, M.D., Charlotte
11:20 A.M.—VIRUSES AND UPPER RESPIRA-
TORY INFECTIONS
Floyd W. Denny, M.D., Professor of
Pediatrics, University of North Caro-
lina, School of Medicine Chapel Hill

11:40 A.M.—CURRENT CHEMOTHERAPY —
Panel Discussion
William W. Shingleton, M.D., Mod-
erator
Professor of Surgery, Duke Uni-
versity Medical Center, Durham
PANEL: Wm. H. Boyce, M. D.
Howard W. Steel, M.D.
Chalmers R. Carr, M.D.
Floyd W. Denny, M.D.

1:00 P.M.—Announcements
ADJOURNMENT

ALUMNI LUNCHEONS

Monday, May 8, 1961, 1:00 P.M.
Duke University Medical School
Alumni Luncheon
Talmadge L. Peele, M.D., Secretary,
Durham
(George Vanderbilt—West Ballroom)
The Medical Alumni Association of
the University of North Carolina
Luncheon
(Battery Park—Gold Room)

2:00 P.M.—HOUSE OF DELEGATES of the
Medical Society reconvenes
(George Vanderbilt—East Ballroom)

- 2:30 P.M.—POSTGRADUATE AND AUDIO-VISUAL PROGRAM
(Asheville City Auditorium — Assembly Hall)
(to be listed in Official Program)
- 2:30 P.M.—Scientific Section Meetings:
Section on Surgery
(Battery Park—Gold Room)
Section on Obstetrics and Gynecology
(Battery Park — Rhododendron Room)
Section on Radiology
(George Vanderbilt—West Ballroom)
Section on Pathology
(George Vanderbilt — Vanderbilt Room)
- 5:20 P.M.—Scientific and Technical Exhibits close.
(Exhibits under supervision of official watchmen)
- 5:45 P.M.—Social Hour and Entertainment for Technical and Scientific Exhibitors by Medical Society
(Country Club of Asheville)
Music: (to be announced)
Introduction by: President Amos N. Johnson, M.D.
- 6:00 P.M.—House of Delegates adjourns Annual Meeting
- 6:00 P.M.—Social Hour—Medical College of Virginia
(Battery Park—Pisgah Room)
- 6:00 P.M.—Social Hour—University of Maryland Medical Alumni Association
(George Vanderbilt—Tropical Room)
- 6:00 P.M.—MSSNC Student Scientific Section Program
- 6:30 P.M.—MSSNC Student Scientific Section Dinner honoring Third Annual Meeting MSSNC Section on Student AMA Chapters
George Vanderbilt West Ballroom
- 6:30 P.M.—Dinner—Medical College of Virginia
(Battery Park—Pisgah Room)
- 6:30 P.M.—Dinner — University of Maryland Medical Alumni Association
(George Vanderbilt—Tropical Room)

PROGRAM

Tuesday, May 9, 1961

- 8:30 A.M.—Scientific and Technical Exhibits open
(Asheville City Auditorium—Exhibit Hall)
- 9:00 A.M.—Registration opens, Booth
(Lower Hall—Asheville City Auditorium)

SECOND GENERAL SESSION

Tuesday, May 9, 1961

- (Asheville City Auditorium—Assembly Hall)
- 9:10 A.M.—CLINICO-PATHOLOGICAL CONFERENCE

Clinical Presentation—

Eugene A. Stead, M.D., Professor and Chairman, Department of Medicine, Duke University Medical Center, Durham

Pathological Presentation—

Kenneth A. Brinkhous, M.D., Professor and Chairman, Department of Pathology, University of North Carolina School of Medicine, Chapel Hill

10:00 A.M.—Address

Julian P. Price, M.D., Chairman, Board of Trustees, American Medical Association.

Florence, S. C.

10:30 A.M.—Break

11:00 A.M.—THE DIFFERENTIAL DIAGNOSIS OF CHEST OR ABDOMINAL PAIN Panel Discussion

Alfred T. Hamilton, M.D., Raleigh, Moderator

PANEL

Thomas C. Worth, M.D., Raleigh

Robert M. McMillan, M.D., Southern Pines

Louis deS. Shaffner, M.D., Winston-Salem

1:00 P.M.—Announcements

Adjournment

ALUMNI LUNCHEONS

Tuesday, May 9, 1961, 1:00 P.M.

Wake Forest Alumni Association of Bowman Gray School of Medicine
(Battery Park—Gold Room)

Medical Advisory Board, North Carolina State Commission for the Blind
(George Vanderbilt—Tropical Room)

2:30 P.M.—POSTGRADUATE AND AUDIO-VISUAL PROGRAM

(Asheville City Auditorium — Assembly Hall)

(to be announced)

SECOND MEETING OF THE HOUSE OF DELEGATES

Tuesday, May 9, 1961, 2:30 P.M.

(George Vanderbilt—East Ballroom)

(Agenda will be available)

2:30 P.M.—Scientific Section Meetings:

Section on General Practice of Medicine

(Battery Park—Gold Room)

Section on Ophthalmology and Otolaryngology

(George Vanderbilt — Vanderbilt Room)

Section on Pediatrics

(Battery Park—Pisgah Room)

Section on Public Health & Education

(Battery Park — Rhododendron Room)
 Section on Anesthesiology
 (Battery Park—Grove Room)
 Section on Orthopaedics & Traumatology
 (George Vanderbilt — West Ballroom)

5:00 P.M.—Exhibits close.

5:30 P.M.—Social Hour
 Jefferson Medical Alumni Association
 (Battery Park — Grove Room)

PRESIDENT'S DINNER

Tuesday, May 9, 1961

(Asheville City Auditorium—Assembly Hall)

7:00 P.M.—Banquet (Admission by ticket only)
 Toastmaster: Hubert McN. Poteat, M.D.

Invocation: (minister to be announced)

7:30 P.M.—Presentation of Guests

7:40 P.M.—Presentation of President's Jewel:
 (to be announced)

7:50 P.M.—Installation of President-Elect,
 Claude B. Squires, M.D., Charlotte
 Administration of Authorized Oath
 of Office

An Address in Acceptance:

Claude B. Squires, M.D., President

An Address:

E. Vincent Askey, M.D., President
 American Medical Association
 Los Angeles, California

8:40 P.M.—Adjourn Banquet Session

9:00 P.M.—Entertainment: (Floor Show to be announced)

10:00 P.M.—2:00 A.M.—PRESIDENT'S BALL
 (Asheville City Auditorium—Assembly Hall)
 (Russ Carlyle and his Orchestra)

THIRD GENERAL SESSION

Wednesday, May 10, 1961

(Asheville City Auditorium—Assembly Hall)

9:30 A.M.—Convening Session

Theodore S. Raiford, M.D., First Vice-President, presiding

9:30 A.M.—Conjoint Session of the North Carolina State Board of Health, Charles R. Bugg, M.D., President, Raleigh, North Carolina

State Board of Health, will preside over this meeting of the Medical Society of the State of North Carolina and the State Board of Health. Charles R. Bugg, M. D., President
 J. W. Roy Norton, M.D., State Health Director

10:00 A.M.—Committee on Scientific Awards,
 Report of:

Lester A. Crowell, Jr., M.D., Chairman, Lincolnton

Recognition and presentation of Moore County, Wake County and Gaston County Awardees:

Associates, Committee on Scientific Awards:

John K. Williford, M.D., Lillington
 Thomas A. Henson, M.D., Greensboro

Ralph W. Coonrad, M.D., Durham
 James B. Lounsbury, M.D., Wilmington

Wm. J. McKinnon, M.D., Wadesboro

Felda Hightower, M.D., Winston-Salem

Joseph M. Hitch, M.D., Raleigh

Vernon W. Taylor, Jr., M.D., Elkin

Mr. Emory Hunt, Consultant, Chapel Hill

10:15 A.M.—Recognition of Fifty Year Club and presentation of Fifty Year Club Certificates and Pins

10:30 A.M.—An Address: Floyd L. Wergeland, Brigadier General, MC, Executive Director Office For Dependents' Medical Care, Office of the Surgeon General, Washington, D. C.

11:00 A.M.—An Address: Honorable Dale Alford, Congressman from Arkansas
 Washington, D. C.

11:35 A.M.—Presentation: Eugene A. Hargrove, M.D., Superintendent State Hospitals of North Carolina, Raleigh

11:50 A.M.—Mr. William Waddell, President National SAMA
 Duke University Medical Center, Durham

12:00 Noon—Installation of Officers elected by 1961 House of Delegates

12:05 P.M.—Remarks by President: Claude B. Squires, M.D.

12:20 P.M.—Exhibits close

12:30 P.M.—Presentation of Prizes
 ADJOURN SINE DIE

THIRTY-EIGHTH ANNUAL MEETING OF THE

AUXILIARY TO THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

Tentative Convention Program

Sunday, May 7, 1961

8:00 P.M. Memorial Services for departed members of the Medical Society and

Auxiliary
(Gold Room—Battery Park Hotel)

Monday, May 8, 1961

- 9:00 A.M. - 4:00 P.M. Registration
(The Manor)
- 9:00 A.M. Golf Tournament
(Asheville Country Club)
- 9:15 A.M. Finance Committee Meeting
(President's Suite—The Manor)
- 10:00 A.M. Executive Committee Meeting
(Beau Nash Room—The Manor)
- 11:00 A.M. Board of Directors' Meeting
(Beau Nash Room—The Manor)
- 1:00 P.M. President-elect Luncheon
(Biltmore Forest Country Club)
Mrs. George T. Noel, presiding for
out-going and incoming State Of-
ficers, State Committee Chairmen,
Councilors, Past Presidents, County
Presidents and Presidents-elect
- 1:00 P.M. General Luncheon for Members and
Guests
(Asheville Country Club)
- 2:30 P.M. Bridge
(Asheville Country Club)
- 2:30 P.M. Wild Flower Tour up Pisgah
Conducted by Mrs. Stanley Atkins
- 4:30 P.M. Past Presidents' Tea
(105 Cherokee Road)

Tuesday, May 9, 1961

- 9:00 A.M. - 4:00 P.M. Registration
(The Manor)
- 9:00 A.M. House of Delegates' Meeting
(Great Hall—The Manor)
- 10:30 A.M. Intermission for Cokes
- 10:45 A.M. Annual Meeting
(Great Hall—The Manor)
- Special Guests:
Mrs. W. W. Hubbard, Regional
Vice-President, Woman's Auxiliary
to the American Medical Association
Mrs. Henry E. Steadman, Treasur-
er, Auxiliary to the Southern Med-
ical Association

- Soloist: Mrs. John W. Ledbetter
- 12:15 P.M. Installation of Officers
- 12:30 P.M. Adjournment
- 1:00 P.M. Luncheon and Fashion Show
(Colonial Room—The Manor)
Fashions by: John Carrol
Specialty Shop
- 7:00 P.M. Medical Society President's Dinner,
Entertainment, and Ball
(City Auditorium)

Wednesday, May 10, 1961

- 9:00 A.M. - 12:00 Noon Registration
(The Manor)
- 10:00 A.M. Tour of the Biltmore Industries and
Special Display of Rare Editions at
Biltmore House

COMING MEETINGS

Greensboro Academy of Medicine Symposium
—Greensboro, March 30.

Southeastern Psychiatric Association, Annual Meeting—Pine Needles Lodge, Southern Pines, April 3-5.

North Carolina Baptist Hospital and Bowman Gray School of Medicine, House Staff Alumni Day and Annual Meeting—Winston-Salem, April 7.

New Hanover County Medical Society Symposium—Cape Fear Country Club, Wilmington, April 11.

University of North Carolina Medical Alumni Day—Chapel Hill, April 14.

Medical Society of the State of North Carolina, One Hundred Seventh Annual Session—Battery Park and George Vanderbilt Hotels, Asheville, May 6-10.

North Carolina Heart Association, Annual Scientific Session—Robert E. Lee Hotel, Winston-Salem, May 24.

Mountain Top Medical Assembly—Waynesville, June 22-24.

The Seaboard Medical Association of Virginia and North Carolina, Annual Meeting—The Carolinian Hotel, Nags Head, June 16-18.

Westbrook Sanatorium, Fiftieth Anniversary Celebration—Richmond, Virginia, April 15.

South Carolina Medical Association, One Hundred Thirteenth Annual Session—Francis Marion Hotel, Charleston, April 25-27.

West Virginia Academy of Ophthalmology and Otolaryngology—Greenbrier Hotel, White Sulphur Springs, West Virginia, April 6-8.

Virginia Academy of General Practice, Annual Scientific Assembly—Sheraton Park Hotel, Washington, D. C., May 11-14.

American Medical Association, Annual Meeting
—New York, New York, June 26-30.

NEW MEMBERS OF THE STATE SOCIETY

The following physicians joined the Medical Society of the State of North Carolina during the month of January:

Dr. Richard Bowden Smith, 720 Grove St., Salisbury; Dr. Darrel Watson Murray, Box 477, Franklin; Dr. William Wayne Sutton, 305 Hamlet Avenue, Carolina Beach; Dr. Harold Alfred Bauer, The Wilmington Clinic, Wilmington; Dr. Bennie Brooks Ward, 124 Vance St., Wilmington; Dr. John Lawrence Bond, Jr., Doctors Building; Dr. Davey Bingham Stallings, Clinard Rd., Rt. 1, Clemmons; Dr. James Archibald McCallum, 75 Lee Drive, Wilmington; Dr. James Reginald Cochran, Medical Arts Bldg., Laurinburg.

NEW HANOVER COUNTY MEDICAL SYMPOSIUM

The New Hanover County Medical Society Symposium will be presented at the Cape Fear Country Club in Wilmington, on Friday, April 4. The following program has been announced.

Morning Session

- 9:30 A.M. "Occlusive Disease of the Lower Extremities"
Dr. H. William Scott, Professor of Surgery, Vanderbilt University
- 10:30 A.M. Subject to be announced
Dr. Hugh M. Hill, Department of Obstetrics and Gynecology, University of Florida
- 1:00 A.M. Coffee
- 1:15 A.M. Subject to be announced
Dr. Charles S. Petty, Assistant Medical Examiner, State of Maryland, Baltimore
- 2:00 Noon Luncheon

Afternoon Session

- 1:30 P.M. Panel
"Recent Advances in the Physiology and Management of Peptic Ulcer Disease"
Dr. Horace Moore, Wilmington, moderator; Dr. Scott; Dr. John Sessions, Department of Gastroenterology, University of North Carolina
- 3:00 P.M. Coffee
- 3:15 P.M. Panel
"Jaundice in the Newborn"
Dr. J. Buren Sidbury, Wilmington, moderator; Dr. Julian Schorr, Department of Pediatrics, Albert Einstein College of Medicine; Dr. Ralph Moore, Wilmington

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. Robert Bruce Nye, a former University North Carolina student, has been promoted from assistant dean to associate dean of the Jefferson Medical College of Philadelphia. Dr. Nye, a native of Winterville (Pitt County) attended the University from 1921 to 1923 and graduated from the two-year School of Medicine in 1925.

Dr. Nye, a cardiologist has been connected with Jefferson since his graduation in 1927 except for the year of 1938, which was spent in graduate work in cardiology at St. Bartholomew's Hospital, and during World War II when he served in the Army Medical Corps.

* * *

The National Society for Crippled Children and Adults has awarded a \$11,212.50 research grant to two professors in the University of North Carolina School of Medicine, according to

announcement by Dr. Edgar T. Thompson of Duke University, president of the North Carolina Society for Crippled Children and Adults.

The money will be used for research study by Dr. R. Beverly Raney, professor of surgery, and Dr. George K. Summer, assistant professor of pediatrics. It is the fifth of a series of grants, totaling \$67,000, to the two men.

A fund in memory of the late Dr. John A. Lowder, who died in North Carolina Memorial Hospital on October 18, has been established at the University of North Carolina School of Medicine.

The fund, which is known as the John A. Lowder Memorial Fund, has been established by his classmates, friends and family. The income from it is to be used for an annual award or scholarship to a student at the UNC School of Medicine.

Those desiring to contribute may forward checks marked for the fund to the Medical Foundation of North Carolina, U.N.C. School of Medicine, Chapel Hill.

Dr. Robert A. Ross, Head of the Department of Obstetrics and Gynecology, was the guest speaker at the one hundredth anniversary meeting of the Obstetrical Society of Boston (Mass.) on Thursday, January 5.

* * *

The section of Physical Therapy of the School of Medicine has announced plans for an Open House to be held on Saturday, March 18, at Chapel Hill. The purpose of this program will be to acquaint interested students, parents, and educational counselors with the profession of physical therapy.

An international award winning film, "The Return," will be shown. This film depicts the story of a young patient with a spinal cord injury and the physical therapy involved in his rehabilitation.

There will be a discussion of the high school and college academic preparation for physical therapy and a tour of the North Carolina Memorial Hospital Department of Physical Therapy.

All interested high school and college students and guidance counselors are invited to make plans to attend.

* * *

Dr. Joan V. Williams, instructor in psychology in the Department of Psychiatry, has been promoted to assistant professor.

* * *

Three members of the Orthopedic Division of the School of Medicine attended the annual meeting of the American Academy of Orthopedic Surgeons at Miami Beach January 8 to 13. Dr. Richard B. Raney, professor of Orthopedic Surgery was elected vice president of the Academy for 1961.

Dr. H. Robert Brasher, associate professor of orthopedic surgery, was nominated as an Academy candidate for the American Board of Orthopedic Surgery.

Dr. Wayne H. Akesson, assistant professor of orthopedic surgery, spoke on "An Experimental Study of Joint Stiffness" at the seventh annual meeting of the Orthopedic Research Society which was held in connection with the Academy meeting.

Six-week postgraduate courses in medicine, sponsored by the University of North Carolina School of Medicine, are being held in Hickory, Statesville and in Lumberton. The first course began at Hickory on Tuesday, February 28 and will be held at Statesville on alternate Tuesdays. The second course began at Lumberton on Wednesday, March 1.

The Hickory-Statesville course is co-sponsored by the Catawba-Iredell-Alexander Medical Society. The course in Elkin is co-sponsored by the Robeson County Medical Society.

Both courses are acceptable for credit by the American Academy of General Practice for the number of hours attended by the individual physicians.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

Dr. Henry D. McIntosh, associate professor of medicine at the Duke University Medical Center, has been elected vice chairman of the Southern Section of the American Federation for Clinical Research. Elections were held during the Section's annual meeting in New Orleans. Dr. McIntosh will serve for one year.

Dr. McIntosh, a Duke faculty member since 1955, served during 1959-60 as president of the North Carolina Heart Association. He is the author of a number of scientific papers dealing with the circulatory system.

* * *

Dr. Roger D. Baker, professor of pathology at the Duke University Center and chief of the laboratory service at the Veterans Administration Hospital here, has been named head of the American Board of Pathology.

Dr. Baker will serve during 1961 as president of the trustees of the Board, which certifies specialists in pathology, the branch of medical science dealing with the origin and nature of diseases.

* * *

Dr. Walter R. Guild, associate professor of biophysics at Duke University Medical Center is conducting a research project to uncover new knowledge about heredity through genetic studies at the molecular level.

Funds scheduled to total \$104,287 during the next three years have been allotted to support this work, by the National Institutes of Health.

A Duke University medical scientist, Dr. James B. Wyngaarden (CQ), is co-editor with two other doctors of a major new book on inherited body chemistry diseases.

Published by McGraw-Hill Book Co., the 1,477-page work is entitled "The Metabolic Basis of Inherited Disease." It is designed to provide students, researchers and certain specialists with clinical, biochemical and genetic information concerning inherited metabolic (body chemistry) diseases.

Contributors to the book include Dr. Charles H. Burnett, chairman of the Department of Medicine, University of North Carolina School of Medicine; Dr. T. Franklin Williams, assistant professor of medicine at U.N.C., and Drs. T. David Elder and R. Rodney Howell, both research fellows at Duke.

* * *

A new program aimed at learning more about cerebral palsy is being initiated by the Duke University Medical Center and the North Carolina Cerebral Palsy Hospital in Durham.

The joint research effort will be supported by grants from the National Institutes of Health, principal research arm of the U. S. Public Health Service. Funds totaling \$108,400 have been allotted for the first five years of operation.

Dr. Blaine S. Nashold Jr., associate professor of neurosurgery, and Dr. Lenox D. Baker, professor of orthopedic surgery, both of the Duke University Medical Center faculty, will head the program. Dr. Baker is medical director of the North Carolina Cerebral Palsy Hospital and was instrumental in its establishment in 1949.

* * *

An extensive new program of development has been initiated in the Duke University Medical Center's Pathology Department, Dr. Barnes Woodhall, dean of the School of Medicine, announced recently.

This year, approximately \$500,000 will be spent on renovation and alteration of existing facilities, purchase of new research equipment, and support of scientific investigations by faculty members. The bulk of this amount will be provided by grants from the National Institutes of Health, which is the research arm of the U. S. Public Health Service.

The pathology faculty is being increased and by next summer will include 12 members with the rank of assistant professor or higher.

* * *

Dr. E. C. Hamblen, professor of endocrinology in the Duke University Medical Center's obstetrics-gynecology department, left recently for a six-week research and lecture tour in Central and South America.

The major purpose of this trip is to collect and correlate data from research studies dealing with endocrine glands.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. William H. Boyce, professor and chairman of the medical school's section on urology, participated in a Medical College of South Carolina postgraduate seminar, February 23, at Charleston, South Carolina. He spoke on "Urinary factors in Stone Formation," and led round table discussions on the same topic.

* * *

Dr. Harold D. Green, Gordon Gray Professor of Physiology, has been named to the scientific council of the Institute for Advancement of Medical Communication, an organization devoted to the development and exploration of new methods and media for transmitting information within bio-medical professions.

* * *

Mrs. Ethel M. Nash, an assistant in preventive medicine (marriage counselor), delivered a series of three lectures on "What a Marriage Counselor Can Do" at Bennett Junior College, Millbrook, New York, February 6 through 10. She also gave a series of lectures on "Courtship and Engagement as Marital Adjustment Predictors" at the University of Cincinnati, February 16 through 19.

* * *

Dr. Frank R. Lock, professor of obstetrics and gynecology, was honored February 16 at a banquet given by former obstetrics-gynecology residents at the N. C. Baptist Hospital and the Bowman Gray School of Medicine. More than 100 persons attended the event, which was held in conjunction with a meeting in Atlanta of the South Atlanta Association of Obstetricians and Gynecologists.

On February 7, Dr. Lock spoke on "Rubella in pregnancy" at a meeting of the Buffalo (N. Y.) Obstetrics and Gynecological Society. On February 20, he spoke on his rubella studies to the faculty and house staff of the University of Maryland School of Medicine at Baltimore.

* * *

Dr. Martin G. Netsky, professor of neurology and neuropathology, has been named an assistant examiner for the American Board of Psychiatry and Neurology.

Dr. Isadore Meschan, professor of radiology, served as instructor during the week of February 13 to March 3 in the radiology section of the Armed Forces Institute of Pathology.

Dr. Frank H. Hulcher, assistant professor of biochemistry, was awarded a \$21,333 grant from the National Multiple Sclerosis Society. The funds will support a one-year project entitled "Chemical and Metabolic Studies on Myelin."

* * *

Postgraduate Course

The Annual postgraduate course in obstetrics and pediatrics will be held March 21-23 under the joint auspices of the North Carolina State

Board of Health and the Bowman Gray School of Medicine. The program is designed primarily for physicians in the general practice of medicine who assist in the state maternal and child welfare programs.

Registration is limited to 65, and those interested in attending the sessions should apply in advance.

* * *

Coming Academic Events

March 27, 1961, 7:30 p.m., clinical amphitheater: Bowman Gray Medical Society program with Dr. Arnold Welch, professor of pharmacology at the Yale University School of Medicine at New Haven, Connecticut.

April 10, 1961, 7:30 p.m., clinical amphitheater: Student American Medical Association program with Dr. Charles H. Rammelkamp, director of medicine, Cleveland Metropolitan Hospital, Cleveland, Ohio, speaking on "The Microbiologist's View of Rheumatic Fever and Rheumatic Heart Disease."

April 17, 1961, 7:30 p.m., clinical amphitheater: Medical Education in National Defense program with Maj. Milton Rubini, MC, Division of Medicine, Walter Reed Army Medical Center, Washington, D. C., speaking on "Tropical Sprue and Nutritional Megaloblastic Anemias."

EDGECOMBE-NASH MEDICAL SOCIETY

The regular meeting of The Edgecombe-Nash County Medical Society was held in Rocky Mount on February 8.

Dr. J. S. Brock, program chairman, introduced Dr. George Baylin, professor of radiology at Duke, to talk on "The Radiological Aspects of Certain Chest Signs and Symptoms."

ROBESON COUNTY MEDICAL SOCIETY

The February meeting of the Robeson County Medical Society was sponsored by the Robeson County Unit of the American Cancer Society. Dr. Walter Benson, assistant professor of pathology, University of North Carolina Medical School, spoke on "Carcinoma of The Lung."

The executive committee of the Robeson County Unit were guests of the society for this meeting.

FORSYTH COUNTY MEDICAL SOCIETY

Dr. E. Harvey Estes, Jr., associate professor of medicine, Duke University School of Medicine, was speaker at the regular dinner meeting of the Forsyth County Medical Society held in Winston-Salem on February 14. His subject was "Free Fatty acids in Blood: Clinical and Experimental Significance."

NEWS NOTES

Drs. Henry W. Johnson, Robert L. Vann, D. Russell Perry, and Kenan B. Williams of Winston-Salem have announced their association for the practice of pediatrics under the name of Pediatrics Associates. Offices are located at Doctors Center on Miller Street in Winston-Salem.

AMERICAN HEART ASSOCIATION

The 1961 Annual Meeting and Scientific Sessions of the American Heart Association will be held in Bal Harbour, Miami Beach, Florida, October 20-24. The thirty-fourth annual Scientific Sessions are scheduled from Friday, October 20, through Sunday, October 22, in the Americana Hotel.

May 15 has been set as the deadline for submitting abstracts of papers to be presented at the Scientific Sessions. Papers intended for presentation must be based on original investigations in, or related to, the cardiovascular field. Official forms for submitting abstracts may be obtained from Richard E. Hurley, M.D., Medical Associate, American Heart Association, 44 East 23rd Street, New York 10, New York. Applications for scientific exhibit space, due May 15, are also available from Dr. Hurley.

WESTBROOK SANATORIUM

The Board of Directors of Westbrook Sanatorium announces the retirement, effective January 1, 1961, of Dr. Paul V. Anderson. Dr. Rex Blankinship succeeds Dr. Anderson as president of the sanatorium.

Dr. John R. Saunders is medical director, succeeding Dr. Rex Blankinship; and Dr. T. F. Coates, Jr., is assistant medical director. Dr. J. K. Hall, Jr., was elected to the Board of Directors.

* * *

The Board of Directors and staff of Westbrook Sanatorium will soon issue invitations for the celebration of the fiftieth anniversary of the founding of Westbrook Sanatorium in 1911. As a part of the celebration the sanatorium will be host to the Neuropsychiatric Society of Virginia, a District Branch of the American Psychiatric Association, on April 15 at 2 p.m. The guest speakers will be Dr. Robert H. Felix, president of the American Psychiatric Association; Dr. Francis J. Braceland, psychiatrist in chief, the Institute of Living, Hartford, Connecticut, and past president of the American Psychiatric Association; and Dr. Mathew Ross, medical director of the American Psychiatric Association. Also appearing on the program will be Dr. Guy W. Horsley, president of the Medical Society of Virginia, and Dr. Edwin L. Kendig, Jr., president of the Richmond Academy of Medicine.

AMERICAN COLLEGE OF GASTROENTEROLOGY

The Southern Regional Meeting of the American College of Gastroenterology will be held in Houston, Texas on Sunday, March 19.

Members of the medical profession are cordially invited to attend. A copy of the program may be obtained from the Secretary, American College of Gastroenterology, 33 West 60th Street, New York 23, N. Y.

A.M.A. MEDICOLEGAL CONFERENCE

An outstanding program on medicine and the law will be presented at the Kentucky Hotel in Louisville, April 14-15.

The Regional Medicolegal Conference sponsored by the American Medical Association Legal and Socio-Economic Division.

The Louisville meeting is the second in a series of three medicolegal meetings being sponsored by the A.M.A. this year. It will draw registrants primarily from Kentucky, Tennessee, Indiana, Illinois, Ohio, West Virginia, Virginia, North Carolina, Georgia, Alabama, South Carolina, Mississippi, Arkansas, Missouri, Wisconsin and Florida.

All those who intend to attend the meeting are asked to make their own hotel reservation.

Registration fee will be \$5 to cover the cost of a luncheon on Saturday and a copy of the proceedings. Advance registration cards may be obtained by writing: C. Joseph Stetler, Director, Legal and Socio-Economic Division, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

AMERICAN ASSOCIATION OF MEDICAL CLINIC

Dr. Harold D. Caylor of the Caylor-Nick Clinic in Bluffton, Indiana, became the new president of the American Association of Medical Clinics at the Association's recent eleventh annual meeting in New Orleans. Dr. Caylor succeeded Dr. Russel V. Lee of Palo Alto, California.

President-elect is Dr. Bernard A. Watson of the Clifton Springs Sanitarium Clinic, New York. Dr. John R. Hand of Portland, Oregon, was elected second vice president; and Dr. Joseph B. Davy of Marion, Indiana, was re-elected secretary-treasurer.

AMERICAN BOARD OF OBSTETRICS
AND GYNECOLOGY

The next scheduled examinations (Part 11 oral and clinical for all candidates will be conducted at the Edgewater Beach Hotel, Chicago, Illinois, by the entire Board from April 8 through 15, 1961. Formal notice of the exact time of each

candidate's examination will be sent him in advance of the examination dates.

Candidates who participated in the Part 1 examinations will be notified of their eligibility for Part 11 as soon as possible.

All candidates, eligible for the Part 11 examinations, who have applied for the first time in 1960, will be required to submit a duplicate list of the hospital admissions as contained in their application.

The deadline date for the receipt of new and reopened applications for the 1962 examinations is August 1, 1961. Candidates are urged to submit their applications as soon as possible before that time.

Robert L. Faulkner, M.D.
2105 Adelbert Road
Cleveland 6, Ohio

WORLD MEDICAL ASSOCIATION

The Headquarters Secretariat of The World Medical Association regrettably announces the death of its Secretary General, Dr. Heinz Lord, on February 3, 1961, in Chicago, Illinois. Dr. Lord was recently appointed to replace Dr. Louis H. Bauer, who retired from the position.

DEPARTMENT OF HEALTH, EDUCATION AND WELFARE

Commissioner of Food and Drugs George P. Larrick recently announced that a panel of distinguished physicians appointed by the National Research Council at FDA's request has found that the antibiotic, Chloromycetin (chloramphenicol) is a valuable drug that should remain on the market for use in treating serious infections under medical supervision both in hospitals and for treatment of patients in the home. The panel also recommended revision of the labeling of the drug to give added emphasis to the warnings against its use in minor infections and calling attention to the necessity for adequate blood studies when use is required.

These findings are in complete accord with the conclusions reached by the Food and Drug Administration before the matter was referred to the National Research Council.

The Commissioner also announced that the manufacturer of Chloromycetin, Parke, Davis and Company, Detroit, Michigan, is cooperating in relabeling the drug in compliance with these recommendations.

* * *

The Public Health Service has announced the award of 35 project grants for graduate training in public health totaling \$824,600. These grants were awarded to 24 schools in 15 States and Puerto Rico.

Two of the grants were awarded to the University of North Carolina School of Public Health

—\$21,527 for training in public health administration, and \$16,308 for training in air hygiene and pollution.

* * *

Establishment of three new divisions in the Bureau of State Services of the Public Health Service has been announced by Surgeon General Designate Luther L. Terry.

The three new divisions, Accident Prevention, Chronic Diseases, and Community Health Practice, are created as part of a Service-wide reorganization designed to strengthen and expand present programs and to provide more assistance to State and community health departments.

* * *

Among the greater metropolitan areas with populations of a million or over, the Boston area has the highest ratio of physicians to population, according to a report issued recently by the Public Health Service.

Entitled "Health Manpower Source Book, Section 10: Physicians' Age, Type of Practice, and Location," the report reveals the numbers and locations of physicians, osteopaths, dentists, and veterinarians by region, State, county, and standard metropolitan statistical area.

Listed as Public Health Service Publication No. 263, Section 10, it may be purchased from the Superintendent of Documents, Government Printing Office, Washington 25, D. C. at 55 cents per copy. Single free copies may be obtained from the Public Health Service, Washington 25, D. C.

VETERANS ADMINISTRATION

A reminder to any of the remaining Spanish-American War veterans who desire outpatient care from private physicians at VA expense was issued recently by the Veterans Administration.

Such veterans, the VA said, should notify the nearest VA office immediately. For most veterans of this war, the VA can pay for outpatient care from private physicians only when it has been authorized by the agency before the treatment is given.

In emergency cases, however, the VA may issue an authorization for emergency non-hospital treatment already given, when the agency is notified by the veteran or his physician within 15 days from the date treatment began.

Veterans Administration records show that there were 34,000 living Spanish-American War veterans as of November 30, 1960.

* * *

Gastroenterologists at 14 Veterans Administration hospitals have formed a cooperative study group for research to improve treatment for patients in their specialty.

Their first project is a study of benefits of surgical treatment as compared to benefits of medical treatment for gastric ulcers.

Book Reviews

Aid to Gynaecology. By W. R. Winterton. Edition 12, 214 pages. Price, \$3.00. Baltimore: The Williams & Wilkins Company, 1960.

This is the twelfth edition of an outline book intended for students' use that covers the entire area of gynaecology completely, although rather superficially. However, in specific areas the coverage is more comprehensive, especially those paragraphs devoted to the menopausal and postmenopausal female. Here the author emphasizes those retrogressive changes that are expected at this period and describes the changes that occur in the so called "normal" individual. In other areas, excellent practical points are emphasized.

Being of British origin, the author describes therapy, especially operative therapy, that is at variance with most American authorities. In particular, the coverage of oncologic gynaecology is incomplete and at times incorrect. The definitions given for the International staging of cervical carcinoma differ from those described

generally. Only a few paragraphs are devoted to the new prophylactic and diagnostic field of gynaecologic cytology. The description of the treatment of cervical carcinoma occurring in pregnancy and of endometrial carcinoma requires clarification and expansion. Excluding that portion of the book devoted to therapy, the book is most adequate in its field.

Nine Months' Reading: A Medical Guide for Pregnant Women. By Robert E. Hall, M.D. 191 pages. Price, \$2.95. Garden City, New York: Doubleday & Company, Inc., 1960.

Dr. Hall's experience in obstetrics, his common sense approach, and his clear and precise presentation of the medical facts associated with pregnancy combine to make this book one of the best of the multitude of books currently being published on this subject. In 10 short chapters he covers the development of the fetus, normal labor and delivery, complications of pregnancy, and abnormal labor in a manner that answers most pertinent questions without arousing excessive apprehension in the mind of the pregnant woman. In particular, his chapters on



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Rules and Regulations, Motherhood in the Hospital and at Home, and The Patient and her Doctor are very sensibly written, and should dispel many of the problems inherent in pregnancy and the puerperium from the selection of a physician through the six-week postpartum check. A glossary of obstetric terms, which is essential for a book of this type, is appended.

Pain and Itch: Nervous Mechanism. By Ciba Foundation Study Group No. 1. 120 pages. Price, \$2.50. Boston: Little-Brown & Company, 1959.

This 120 page Ciba Foundation symposium contains eight penetrating discussions of pain by 20 accomplished researchers. Each of the essayists reviews his major contributions and is criticized appropriately, with a minimum of platitudes and electrophysiologic jargon.

This consideration of pain and itch could have been divided into an analysis of terminals in the skin, afferent conduction, and cerebral receptors. Weddell summarizes reasons for believing free nerve endings respond to touch and temperature changes as well as pain. Conclusions based on

stimulation of the cornea are criticized because of the unique innervation of that organ.

Douglass and Ritchie, and Iggo attempt to identify the tiny C fiber impulses in mammals by using antidromic volleys to occlude afferent impulses. Iggo recorded relatively specific responses to temperature change, touch, and mechanical stimulation of single C fibers. Douglass and Ritchie describe the responses of bundles of C fibers to the same kinds of stimulation used by Iggo, but implied that all C fibers have similar sensitivities. Strangely, the fibers mediating "slow" pain remain either unseparated from C fibers conveying other modalities of sensation or are represented by potentials too small to record.

Zotterman concludes that both itch and tickle are similar to pain because tickle-like stimuli evoke C fiber activity. Landgran discusses his data, showing that 75 per cent of cortical units in the sensory projection of the tongue responded to only one modality. Arthur and Shelley evaluate a variety of protein substances causing itch, and describe "itch spots," whose specificity is not correlated with neuroanatomic findings.

This is a stimulating booklet for anyone interested in the physiology of pain.



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for dosage and packaging.

Protected by U. S. Patent Numbers:
2,661,372 and 2,661,373

Infectious Diseases of Children. By Saul Krugman, M.D. and Robert Ward, M.D. Edition 2, 398 pages. Price, \$13.00. St. Louis: C. V. Mosby Co. 1960.

Infectious Diseases of Children, unlike most textbooks, is one that can be read from beginning to end. The chapters are concise, clearly written, and well illustrated with case reports, figures, and photographs. The drawings showing the distribution of the rash in various exanthems and the schematic diagrams of the typical clinical course of each disease are valuable to the medical student, who may rarely see the common acute diseases of childhood in a university medical center. The generalizations made by the authors are well documented by selected references to laboratory and clinical experiments. The therapy recommended is specific enough that the practitioner need not look elsewhere for further details.

Although the authors state that this text is not intended to be all-inclusive, most of the diseases omitted are either not prevalent in this country or are themselves the subject of entire volumes. Those which are included are discussed completely — from the properties of the infectious agent to the therapy of the patients' contacts.

In the 1960 edition all chapters have minor additions. One new chapter discusses rabies, with particular reference to protection after animal bites. The other new chapter, on acute respiratory infections, covers all presently described respiratory viruses.

The text is, in general, accurate and very carefully written. However, a few criticisms should be made. Unlike the chapter which discusses only the rickettsial diseases which occur in the United States, the chapter on arthropod-borne encephalidites includes some unnecessary material on the Japanese, Russian, and Australian viruses — not in keeping with the selectivity that characterizes the rest of the book. In the chapter on bacterial meningitis, the importance of the pharmacology of the preparation of a drug used is indicated in the authors' discussion of the effects of suspension particle size and heat stability of the palmitate of chloramphenicol on final blood levels. However, sulfadiazine and sulfisoxazole, which differ significantly in degree of inactivation and penetration into the cerebrospinal fluid, are grouped together in a single dosage schedule for sulfonamides. The importance of determining blood sulfa levels during the therapy of meningitis is not mentioned.

One wonders if medical science is advancing so rapidly that it is necessary to have a second edition of this text only two years after the first edition. Too frequent revision of textbooks implies an instability in fundamental principals

which does not exist. The value of this book is not the recency of the factual information which it has, but rather the authors' judgment in the selection and organization of its contents.

Anyone who owns the 1958 edition would probably be aware of recent information on oral poliomyelitis vaccines, chloramphenicol toxicity and acquired toxoplasmosis. Anyone who has not seen the 1958 edition and who deals with infectious diseases in children or adults would find this a brief, convenient reference book to own. The organization of this text around experimentally verified data makes it unlikely that it will soon become outdated and forms a basis for the physician to interpret and integrate future observations in the field of infectious diseases.

Positive Health of Older People

The book, "Positive Health of Older People," provides a compact, timely resource with a fresh point of view which emphasizes the positive aspects of aging. The 131-page paperback, quoting authorities who spoke at the National Health Council's 1960 Health Forum, reveals the latest developments in the numerous fields that impinge on the well-being of the elderly, and enumerates practical suggestions for action to be taken by individuals, industry, the health professions, voluntary health and welfare agencies, and government.

Brought together in this one volume are statements by physicians, educators, sociologists, economists, biological and medical researchers, clergymen; experts in housing, insurance and personnel administration; psychiatrists, nurses, dentists, social workers, dietitians; officials in public health and welfare; heads of hospitals, clinics, nursing homes and other institutions; leaders in business, labor and voluntary organizations.

Among the subjects discussed are the changing attitudes toward aging; investigation and discovery in physical aging, in mental and emotional health, and rehabilitation; new approaches to health services; retirement planning; institutional services; trends in cultural and family patterns; housing; community activities; and goals for the future.

More than 80 per cent of the funds used to pay the student's costs of medical education come from the student and his family, a report by the Association of American Medical Colleges shows

The Month in Washington

President Kennedy asked Congress to increase Social Security taxes to finance limited medical care for elderly persons on the Social Security rolls, a plan opposed by the medical profession.

The proposal was part of a sweeping health program outlined by Kennedy in a special message to Congress during his first month in the White House.

The Kennedy program also included federal aid for construction and operation of medical schools, scholarships for medical and dental students, grants for community nursing and hospital services, stepped-up medical research, and expanded federal activity in the field of child and youth health.

Under Kennedy's proposal, Social Security beneficiaries 65 years and older could get up to 90 days of hospitalization for each single illness. However, the patient would have to pay \$10 daily for the first nine days of hospitalization with a minimum payment of \$20.

After release from a hospital, the elderly person could get up to 180 days in a nursing home. The Social Security program also provides for payment by the government of 100 per cent of outpatient diagnostic costs in excess of \$20 and community visiting nurse services.

The program would be financed by increased Social Security taxes by one-fourth of one per cent on both employers and workers and by three-eighths of one per cent of self-employed persons covered by Social Security. The Social Security tax base also would be increased from the present \$4,800 a year to \$5,000.

Enactment of this proposal, coupled with another Kennedy recommendation and increases in the Social Security tax already scheduled in the law, would mean that workers and employers would be paying \$50 each in Social Security taxes in 1969.

Nationwide television audiences were told by an American Medical Association spokesman why the medical profession supports the Kerr-Mills program of medical

care for the aged and opposes tying it in with Social Security.

In television debates with Senator Hubert Humphrey (D., Minn.) on NBC-TV and Walter Reuther, organized labor spokesman, on CBS-TV, Dr. Edward R. Annis of Miami, Florida, described the Kerr-Mills program as "sound and effective." He said it "must be given the chance it deserves."

"Congress passed it because it believed that the important thing was to help the people who need help; to help them quickly; and to help them through the machinery of local government," Dr. Annis said.

The A.M.A. Board of Trustees charged the CBS network with "misrepresentations, bias, and distortions" on another program: "The Business of Health in—Medicine, Money and Politics."

The network edited out of the taped program the A.M.A.'s true position on health care for the aged:

"The A.M.A. believes that any medical care plan is both unsound and unfair which would compel working people to shoulder increased Social Security taxes to finance health costs of all those over 65 (under Social Security), rich and poor alike, regardless of whether they want or need such help and which, at the same time, ignore millions of indigent elderly who do not need help."

Kennedy's health program faced strong opposition in Congress. The consensus of Capital Hill observers was that it stood a 50-50 chance of getting Congressional approval, but not before it had been cut down. There were some who doubted that the Administration's program for medical care of the aged would be acted upon, at least by both houses of Congress before next year.

Arthur H. Motley, president of the Chamber of Commerce of the United States, warned that Social Security taxes are being increased to a point "where people might rebel against the whole Social Security system."

He contended that this nation's present personal medical care system is the best of any large nation.

"It's worth crusading for and that is what the Chamber is doing," Motley said.

From the Washington Office of the American Medical Association

In Memoriam

S. Raymond Thompson, M.D.

The members of the Mecklenburg County Medical Society were saddened by the death of one of its members, S. Raymond Thompson, on December 10, 1960.

Dr. Thompson was born in Lumberton, North Carolina, on September 2, 1890, the son of the late Betty Griffin and Jacob Thompson. He attended the local public schools and received his medical education at the North Carolina Medical College, Charlotte, from which he was graduated in 1914. Immediately after graduation he began the practice of urology in association with the late Dr. A. J. Crowell in Charlotte. With the exception of two years of military service in 1917 and 1918, he continued in his chosen specialty until his retirement in 1950 because of ill health. Dr. Thompson held the unique distinction of being the second physician in North Carolina to limit his practice exclusively to urology.

Dr. Thompson was made a fellow of the American College of Surgeons in 1922. He was president of the Mecklenburg Medical Society in 1932, president of the Seventh District Medical Society in 1935, and president of the Tri-State Medical Society in 1947. Until his retirement he was an active member of the American Medical Society, the American Urological Association, and the Southeastern Section of the American Medical Association.

Dr. Thompson was an ardent student of urology and, during his active years, contributed at least 35 scientific articles to medical literature. From 1941 to 1948 he was editor of the Urology Department of the **Tri-State Medical Journal**.

In 1925, Dr. Thompson married Mary Covington Entwistle of Rockingham. He was the father of two children, S. Raymond Thompson, Jr., and Johan Thompson Newcombe. He is survived by his wife, daughter, two grandchildren, and four sisters. He was a member of the Myers Park Methodist church. He was also a member of the

Charlotte Country Club and the Charlotte Country Club.

Dr. Thompson was not only skilled in the science of medicine, but also in the art of medicine. He was noted for his cordiality to physicians and patients alike. Tolerance and kindness were ever present in his relationships with others. The members of the Mecklenburg County Medical Society feel a great loss in the passing of our friend and colleague.

Walter F. Daniel, M.D.

John P. Kennedy, M.D.

Elias S. Faison, M.D.

Wesson Fund Awards New Grants

The Wesson Fund for Medical Research and Education has announced seven grants totaling \$16,965 for basic and clinical research relating to the influence of edible fats and oils on human nutrition.

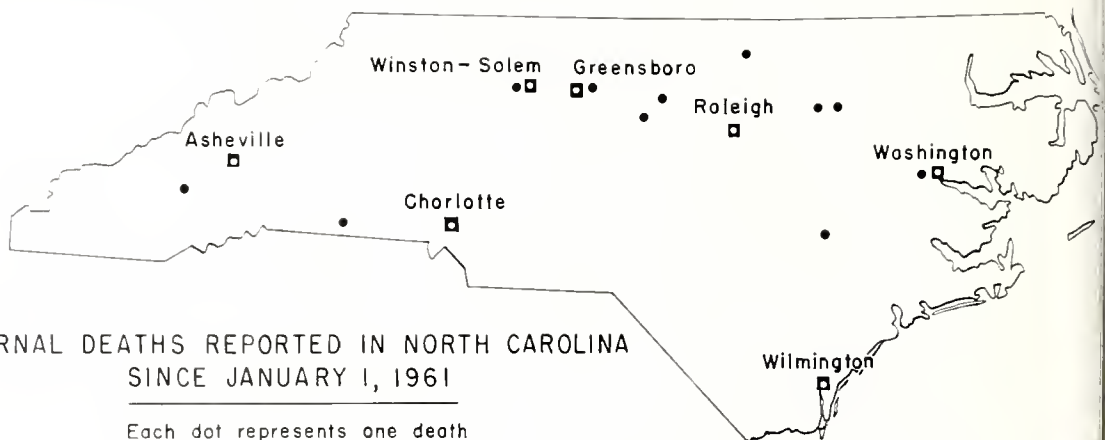
The new awards bring the total of Wesson Fund grants made in 1960 to \$108,916.

Blue Shield Film Made Available

Almost 3,000 prints of the new Blue Shield sound and color filmstrip, "The Guardians," have been distributed to secondary schools by local Blue Shield Plans. It was reported recently by the National Association of Blue Shield Plans.

The Blue Shield filmstrip was produced as a public service to upper elementary and high schools and made available by Blue Shield Plans last fall.

"The Guardians" seeks to give young people an understanding of the never-ending struggle of the medical profession to overcome disease, and of the progress of medicine through the ages with emphasis on the dramatic advances made within the 20th century. Specifically, the filmstrip seeks to develop appreciation of the contribution to the public's health made by the "guardian" of health, the physician, and to encourage students to become more aware of the need for development of individual responsibility especially in planning ahead to meet the cost of any necessary future medical care.



NORTH CAROLINA

Medical Journal



April, 1961
Vol. 22 No. 4

IN THIS ISSUE:

Schizophrenia in the Negro Race in North Carolina

M. M. Vitols, M.D.

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1. Bagnall, A. W.: Antimalarial compounds in rheumatoid disease, *Canad. M.A.J.* 82:1167, June 4, 1960.

2. Cornbleet, Theodore: Discoid lupus erythematosus treated with Plaquenil, *A.M.A. Arch. Dermat.* 73:572, June, 1956.

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NORTH CAROLINA MEDICAL JOURNAL

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THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

VOLUME 22

APRIL, 1961

No. 4

The Significance of the Higher Incidence of Schizophrenia in the Negro Race in North Carolina

M. M. VITOLS, M.D.*
GOLDSBORO

This paper deals primarily with the comparative incidence of schizophrenia in the Negro and white populations of the State of North Carolina. The first admissions of white patients to the state psychiatric hospitals at Raleigh, Morganton, and Butner are compared with first admissions of Negroes to the State Hospital at Goldsboro†. The latter institution serves the entire Negro population of the state.

Having worked at one of the white institutions before coming to Goldsboro, I suspected that the incidence of schizophrenia was higher among Negro first admissions than among those of white patients. The hypothesis was that in North Carolina the incidence of schizophrenia is greater in the Negro race than in the white race. If this is true, what factors are responsible for the difference?

First, the possibility of heredity as a causative factor may be questioned, but will not be discussed at this time because of lack of material.

Lin¹ has reported that schizophrenia is more prevalent in the lower socioeconomic groups in races other than Negro. In addition to his lower socioeconomic status, specific genetic and dynamic factors are believed to contribute toward the higher incidence

of schizophrenia in the Negro. The forces involved in genesis, predominately those of early life-experiences and individual reactions, provide material for unhealthy identification and deprivation with little gratification in a disturbing family atmosphere during childhood. The result is early anxiety. Such forces, if persistent and consistent, lead to the development of a personality which is vulnerable to the stresses of life. The dynamic forces operating later in the individual, consisting of internal pressures (drives, motives, intentions, and anxiety) and environmental pressures, together with the genetic forces, may be specific in the Negro and may lead to the symptoms, personality problems, and disturbed interpersonal relations encountered in schizophrenia.

Statistical data regarding mental illness give little consideration to racial differences, and relatively few of the innumerable papers on schizophrenia deal with mental disorder among racial and ethnic groups. Fewer still deal with mental illnesses in the Negro race.

Review of the Literature

O'Malley², in 1914, showed that dementia praecox is a preponderant mental disease entity in the Negro race. Wagner³ reported, in a comparative study of Negro and white admissions to the Psychiatric Pavilion of Cincinnati General Hospital, that the incidence of schizophrenia was 16.2 per 100,000 white population and 26.3 per 100,000 Negro population.

In 1935 Malzberg⁴ reported that the ratio

Read before the Section on Neurology and Psychiatry, Medical Society of the State of North Carolina, Raleigh, May 11, 1960.

*Superintendent, Cherry Hospital, Goldsboro, North Carolina.

†In the paper the State Hospitals are referred to by location as follows: Raleigh — Dorothea Dix Hospital; Morganton, Broughton Hospital; Butner — John Umstead Hospital; Goldsboro — Cherry Hospital.

of dementia praecox per 100,000 population was 44.4 in the Negro and 19.2 in the white race. He further reported a striking difference in the schizophrenic personality in the Negro and white races in the State of New York, in his group analysis for 1939 and 1941⁵. The corresponding figure per 100,000 population was 26.2 for whites and 67.0 for Negroes. Malzberg's recently published data will be discussed later in this paper.

Laubscher⁶, in 1937, published a study of mental illness in the natives of South Africa (Cape Providence). He stated that schizophrenia made up 60 per cent of one hospital population, but he does not cite the over-all incidence. However, he developed the general view that the Negro, whether in Africa or America, is especially susceptible to this illness. He also held that a completely hopeless socioeconomic situation is an etiologic factor in the development of psychosis, especially schizophrenia.

Moffson⁷ presented clinical data on schizophrenic admissions in the male Bantu for the years 1952-1954. The relative incidence of admissions for schizophrenia and paranoid psychosis compared with the over-all admissions was 43 to 50.5 per cent, or twice the corresponding figure for European admissions to the same hospital (19.5 to 23 per cent). He readily suggests that this difference might be explained on the basis of cultural and social factors. He also draws attention to the basis upon which hospitalization is determined, pointing out that generally the more excited and disturbed schizophrenic patient will be admitted to the hospital earlier than those who have a slow onset of a schizophrenic reaction. This accounts for the fact that the hospital referred to had so many chronic schizophrenics with a poor prognosis. In Stainbrook's excellent paper⁸ on schizophrenia in the "multi-racial class society" composed largely of Negroes in Bahia, Brazil, he describes the schizophrenic behavior in this group and pleads for joint studies by psychiatrists and anthropologists.

Frumkin⁹, in 1954, while analyzing all first admissions to the Ohio State Mental Hospital for the year 1949, found that the admission rate was two and one-half times

as great for the Negro as for the white race and disproportionately high for the unskilled and the uneducated. From these findings, which actually parallel statistics gathered elsewhere, he developed a simplified theory that the incidence of schizophrenia merely reflects the level of frustration in the poorer class, city-dwelling Negro.

Ripley and Wolf¹⁰, reporting on mental illness in Negro troops overseas, stated that the incidence of psychiatric disorders was appreciably higher in the Negro than in the white troops. On the Island of Biak a psychosis was found to occur 4.9 times as often in the Negro as in the white man. In a white service unit, with an average of 740 men, no psychosis was reported. From three Negro service units, with an average of 541 men, 46 cases of schizophrenia were reported among the 59 psychiatric disorders found. The authors stress the point that they were impressed by the large number of Negroes with schizophrenia, and also that the diagnosis was made with caution.

Faris and Dunham¹¹ in studying the home distribution of more than 20,000 patients admitted to the mental hospitals in Chicago between 1921 and 1931, found that the incidence of schizophrenia in the Negro was low in Negro areas but high in the so-called white sections of the city. The incidence of the disease in the white population showed a corresponding pattern—that is, it was higher in Negro areas than in white areas. It would seem, therefore, that regardless of race, people tend to show a higher incidence of schizophrenia when living in an area populated predominated by another race. Faris and Dunham pointed out, however, (1) that people might drift to mixed areas long before they become ill, and (2) that one cannot rely on the diagnosis given in the hospital records. They concluded that "social isolation"—the fact that in the central areas of the city people tend to be cut off from intimate and lasting emotional relationships—was a causative element in schizophrenia. They pointed out also that the rate of schizophrenia formed a pattern; being highest at the center of the city in areas of economic depression, and lowest on the periphery of the city.

Material

New York State

This material was derived from two sources. Malzberg¹² reported that the leading diagnostic category for first admissions to all mental hospitals in New York State from 1949-1951 was dementia praecox. Of 6,167 Negro first admissions, 2,789 or 45.2 per cent were diagnosed as dementia praecox or schizophrenia, an annual average rate of 101.1 per 100,000 population.

He found that dementia praecox was the prevalent disease of the young and that 50 per cent of the Negro first admissions were under the age of 30 years and 75 per cent were under the age of 35. It is noteworthy that the rate of Negro first admissions with schizophrenic reactions increased by 51 per cent, from a ratio of 67.0 in 1940 to 101.1 in 1950. The white population had a lower rate than the Negro, the average being 32.2 per 100,000, and the white first admissions were significantly older than the Negro. In 1950 the rate of Negro schizophrenic admissions excelled that of the white admissions in the ratio of 3.04 to 1.

The general Negro population of the State of New York is younger than that of the white population and reflects the relative distribution of dementia praecox. Between 1910 and 1950 the number of Negroes in New York increased sevenfold as compared with a 55 per cent increase in the white population, and since 1930 the Negro population has continued to grow rapidly.

At the Goldsboro hospital, admission of schizophrenic patients under the age of 34 comprised 57.7 per cent of the total (table 1, abstracted from table 6-A).

Table 1

Age	Per Cent
10-14	1.
15-19	7.2
20-24	13.3
25-29	20.
30-34	16.2
Total	57.7

North Carolina

The second and main source of material was first admissions to the North Carolina State Hospitals for the period July 1, 1957,

through June 30, 1958. During that period there was a total of 3,510 first admissions—2,766 white and 744 Negro. Negro first admissions constituted 21.1 per cent of the total. The data from Butner refer only to the total number of admissions and the number of schizophrenics.

The first admissions to Goldsboro for schizophrenia were classified according to age, occupation, and other factors (tables 2-8).

As the census was last taken in 1950, we have only an estimation of the population of North Carolina for 1958.* Statistical abstracts of 1958 show the estimated population of North Carolina to be 4,549,000. (The census for 1960 is 4,529,550). In 1950 Negroes constituted about 33 per cent of total population of the state. In a personal communication with Dr. Rupert Vance of the University of North Carolina, Chapel Hill, it was disclosed that many Negroes migrate North to find more suitable employment. I was unable to find any concrete data as to the rate of emigration, but projecting the census figures of 1950, it was assumed that the Negro population in 1958 would be about 30 per cent of the total. The estimated population for 1958 is 3,184,300 whites and 1,364,700 Negroes. It is proposed that this same survey should be repeated when the 1960 census is available.

Factors Influencing the Present Study

A number of factors must be recognized as mere speculation in this attempt to show that schizophrenia is more prevalent in the Negro population than in the white population of North Carolina. It should first be pointed out that figures given here for the total population of the state as well as the percentage of Negroes are estimations, and that the incidence of schizophrenia per 100,000 is computed on this basis. In North Carolina, psychiatric inpatient facilities, university hospitals, Veterans hospitals, and so forth, are available to the white population of the state, and the number of white schizophrenic patients reported would be much greater if it included those treated in

*The total census figures for 1960 were still unavailable in January, 1961, when this paper was written.

Table 2

**Diagnostic Classification of First Admissions to North Carolina State Hospitals
July 1, 1957, through June 30, 1958***

Diagnosis	Morganton			Raleigh			Goldsboro			Butner Total
	Total	M.	F.	Total	M.	F.	Total	M.	F.	
Acute brain syndrome	20	15	3	15	10	5	30	23	7	
Chronic brain syndrome	192	100	92	290	153	137	178	117	61	
Psychotic disorders										
Involuntional psychotic reaction	34	13	21	23	7	16	29	13	16	
Manic depressive reaction	46	15	31	25	10	15	9	6	3	
Psychotic depressive reaction	25	6	19	57	21	36	8		8	
Schizophrenic reaction	153	62	91	119	56	63	367	172	195	239
Paranoid reaction	8	2	6	3		3				
Total psychotic disorders	266	98	168	227	94	133	413	191	222	
Psychophysiologic, autonomic and visceral disorders	9	3	6	5	1	4				
Psychoneurotic reaction	70	31	39	86	46	40	13	11	2	
Personality disorders	18	13	5	113	67	46	10	3	7	
Alcoholism (addiction)	7	6	1	384	336	48	28	17	11	
Transient situational personality disturbance	16	5	11	17	2	15	6	2	4	
Mental deficiency	27	12	15	36	17	19	55	33	22	
Mental disorder, undiagnosed				24	24					
Without mental disorder	7	3	4	29	24	5	11	10	1	
Grand totals	632	286	346	1226	774	452	741	407	337	908

*Data presented in subsequent tables were drawn from the same period.

other facilities. Except for the Veterans Administration hospitals, the Goldsboro hospital is the only known inpatient facility available to Negroes in this state.

The number of first admissions to the Goldsboro hospital does not, however, represent the true picture of the occurrence of psychosis, neurosis, and other mental disorders in the Negro population of North Carolina. Numerous factors would lead to an overestimate of the rate of schizophrenia in this race, one being the limited facilities noted above. It is also possible that the estimated population figure is too low. On the other hand, the estimated rate of schizo-

phrenia may be too low, since in the Negro race deviant behavior is more generally tolerated than in the white race and would therefore be accepted longer outside the institution. The mentally ill Negro also tends to go North. This point will be discussed further in this paper.

Factors determining hospitalization

At this point the facts that determine hospitalization should be considered. Table 6-B shows the duration of schizophrenia in patients before admission to be one year or longer in 38.5 per cent of the cases. The breakdown as to types of schizophrenia

Table 3
First Admissions Diagnostic Categories

Diagnosis	Morganton % of Total	Raleigh % of Total	Goldsboro % of Total	Bntner % of Total
Acute brain syndrome	3.1	1.2	4.1	
Chronic brain syndrome	30.4	23.7	24.	
Psychotic disorders:				
Involutional psychotic reaction	5.4	2.	4.	
Manic depressive reaction	7.3	2.	1.2	
Psychotic depressive reaction	4.0	4.6	1.	
Schizophrenic reaction	24.0	9.7 (14.1)	49.3	26.3
Paranoid reaction	1.3	.2		
Total psychotic disorders	42.0	18.5 (27)	55.5	
Psychophysiologic autonomic and visceral disorders	1.4	0.4		
Psychoneurotic reactions	11.0	7.0	1.7	
Personality disorders	2.9	9.1	1.2	
Alcoholism (addiction)	1.2	31.3	3.8	
Transient situational personality disturbance	2.5	1.4	0.8	
Mental deficiency	4.3	3.0	7.4	
Mental disorder, undiagnosed		2.0		
Without mental disorder	1.2	2.4	1.5	
Grand Totals	100.0	100.0	100.0	

shows that the chronic undifferentiated type is the most prevalent, constituting 59 per cent of the cases. It was also pointed out by Loffson⁷ that hospitalization for psychosis in Africa was determined either by an acute onset or by exhaustion of the family or tribal resources by an extended illness. As mentioned before, Negro culture is known to be considerably more tolerant of deviant behavior, especially in the lower socioeconomic group. Behavior which the white man would label psychopathic is often only a means of upholding prestige in the underprivileged Negro. This is expressed in the management of money, in membership in clubs with fancy names, and in religious observances which are somewhat deviant from other cultural standards. It is felt that in North Carolina the Negro generally seeks

hospitalization only as a last resort. His reluctance to admit members of the family, along with the stigma attached to admission to a state hospital, superimposed upon the inadequate facilities for the care of Negroes in the past, leads to the assumption that only one half, if not less, of the schizophrenics in the Negro population of North Carolina are accounted for. A true picture could be made only from a complete survey of the entire Negro population.

Diagnosis

The matter of diagnosis is also of great importance. Diagnoses vary widely from country to country and from one hospital to another. Different frames of reference are used by clinicians, and this may also influence the number of schizophrenics

Table 4

First Admissions for Schizophrenia

Hospital	No.	Per Cent
Morganton	153	24.0
Raleigh	119	9.7
Butner	239	26.3
Goldsboro	367	49.3

reported by the State Hospitals in North Carolina. The number of first schizophrenic admissions could be higher or lower depending on the diagnostic criteria applied.

Generally, however, Bleuler's criteria were employed for the diagnosis of schizophrenia in the cases reported. When after clinical observation for two to four weeks the patient was found to have inappropriate affect, morbid ambitendency and ambivalence, a tendency to replace reality by fantasy resulting in various manifestations of autism, and the typical loosening of the association links in the thinking processes, a diagnosis of schizophrenia was given. The importance of the differential diagnosis must also be recognized.

Occasionally I have seen patients at this hospital, as well as in the emergency room and outpatient psychiatric facility at North Carolina Memorial Hospital, who presented a clinical picture resembling that of schizophrenia. These patients, some of whom are Negroes, present anxiety, depressive, hysterical, and dissociative reactions with feelings of depersonalization and derealization. Proctor¹³ also has pointed out the similarity between hysteria and schizophrenia, especially in the splitting of the personality which is common to both. Federn¹⁴ has suggested that the difference lies essentially in the fact that in hysteria the split-off or dissociated part of the ego is repressed, while in the schizophrenic it remains conscious. The cases described above are not included in our classification of schizophrenia.

Comparison of Rates at North Carolina State Hospitals

In tables 3 and 4 the incidence of schizo-

Table 5

Distribution of Schizophrenia by Race

White		Negro	
Raleigh	119		
Morganton	153		
Butner	239	Goldsboro	367
Total	511	Total	367

Average rate per

100,000 population: White—16 Negro—26.9

North Carolina population for 1958 (estimated) 4,549,000

Negro population—1,364,700, or 30% of total.

phrenia in first admissions to North Carolina state hospitals is shown to be as follows:

Morganton	24.0%
Raleigh	9.7*
Butner	26.3
Goldsboro	49.3

*Or 14.1 when the large number of alcoholic admissions are excluded.

The Goldsboro figure of 49.3 per cent is significantly higher than that at the other North Carolina state hospitals. This figure compares closely with the figures in the State of New York for the period October 1, 1949 to September 30, 1951, where schizophrenia accounted for 45.2 per cent of the Negro first admissions and only 26.9 of the white admissions.

The apparent rate of schizophrenia per 100,000 population in North Carolina is 16 for the white and 26.9 for the Negro population. In New York the corresponding figures are 33.2 for the white and 101.1 for the Negro. The figures here are less striking however, it would be worth while to investigate the element of chance. On the basis of the estimated population, 263 first admissions in the Negro would be expected to be diagnosed as schizophrenia. The actual number was 367, or 104 more than expected. By chi square analysis this difference could be due to chance, less than one time in a thousand. In other words, the difference is not due to chance, but rather to cause known or unknown.

An attempt has been made to compare the incidence of schizophrenia in Negro ad-

missions to Goldsboro from the districts served by the Raleigh and Morganton state hospitals. Table 7 shows the incidence among first admissions from these districts.

Raleigh district	48.0%
Morganton	58.4%

The sex distribution was approximately equal, as was the distribution between rural and urban areas (table 6-B). It is therefore concluded that there is no great difference in the percentage of schizophrenic first admissions by district, by sex, or by rural-urban areas.

Predisposing Factors in the Negro Race

Migration

Malzberg¹² points out the importance of migration in the incidence of mental illness in the Negro. Carothers¹⁵ also presents evidence that the rate of hospitalization for mental disorders rises in proportion to the number of the tribe employed away from home, meaning that migration and detribalization tend to increase the rate of hospitalization for mental disorders; however, he does not present specific data for schizophrenia in this connection.

In this study particular attention was paid to the effect of migration. This was found to be a negligible factor in first admissions for schizophrenia, constituting only 0.91 per cent of the total (table 6-B). In the initial survey of schizophrenic admissions to Goldsboro, 147 were first selected as potential migrants. A more thorough evaluation, however, disclosed only 4 true migrants. From the 147 initially selected it was interesting to discover that 51 became migrants after the onset of the disease, and that the majority migrated North—New York, Baltimore, Philadelphia—as a result of difficulties within the family and environment. Five of these patients traveled excessively in all directions of the country. These facts support the view that the sick Negro tends to leave his home and environment—usually to migrate North. This was also pointed out by Malzberg. The aspects of the evaluation are dealt with in a separate paper¹⁶.

From the available data it would appear that the higher incidence of schizophrenia in the Negro race in North Carolina is independent of migration, and that it is not due to chance. The causes must be sought for in the heredity, genetic-dynamic forces, culture, and stress.

Socioeconomic status

As seen in the following abstract from table 6-B, Negro schizophrenic admissions to Goldsboro came mostly from the lower socioeconomic group.

Occupation	Male	Female
Farming	20.5%	5.1%
Odd jobs	40.3	4.1
None	10.6	11.2
Domestic		65.8
Totals	71.4	86.2
Skilled	21.6	4.1
Professional	2.3	4.1
Totals	23.9	8.2

Lower-paying jobs constitute 71.4 per cent of the male and 86.2 per cent of the female employment. It can be seen that 65.8 per cent of the women patients had held domestic jobs. Table 6-A and table 8, which is a condensation of the previous table, shows that formal education in the majority of cases is six grades or less. From these data it becomes apparent that we are dealing with persons coming from the lower socioeconomic groups. Lin¹ also stressed the higher rate of schizophrenia in this group.

Socioeconomic factors cannot alone account for the higher incidence of schizophrenia in the Negro race. An attempt is made therefore to discuss the etiologic forces and factors which are peculiar or specific to the Negro.

The hereditary factors are not discussed because of the lack of material.

Family structure

The family structure of the American Negro cannot be overlooked. His is a matriarchal family. As far back as slavery times the mother was more or less the center of the home. She held the family together and the children moved with her wherever she was put to work. The marriage even then was unstable, and the father felt little emotional attachment to the family. It was the

Table 6-A
Distribution of First Schizophrenic Admissions to Goldsboro Hospital
by Marital Status, Ages, and Education

TOTAL: 367

Marital Status	Male		Female		Average
	No.	%	No.	%	%
Married -----	73	42.8	121	61.8	52.3
Single -----	80	46.8	53	27.	36.9
Divorced -----	8	4.6	10	5.1	4.9
Widowed -----	2	1.2	9	4.6	2.9
Unknown -----	8	4.6	3	1.5	3.0
	<u>171</u>	<u>100.0</u>	<u>196</u>	<u>100.0</u>	<u>100.0</u>

Age					
(Years)					
10-14 -----	--	--	4	2.	1.
15-19 -----	15	8.8	11	5.6	7.2
20-24 -----	28	16.4	20	10.2	13.3
25-29 -----	37	21.6	36	18.4	20.
30-34 -----	31	18.1	28	14.3	16.2
35-39 -----	21	12.2	25	12.8	12.5
40-44 -----	15	8.7	32	16.4	12.5
45-49 -----	18	10.6	21	10.7	10.6
50-54 -----	3	1.7	13	6.6	4.2
55-59 -----	2	1.2	3	1.5	1.4
60-over -----	1	.7	3	1.5	1.1
Unknown -----	--	--	--	--	--
	<u>171</u>	<u>100.0</u>	<u>196</u>	<u>100.0</u>	<u>100.0</u>

Education					
Unknown -----	7	4.	12	6.1	5.
None -----	9	5.4	10	5.1	5.3
1st Grade -----	4	2.3	3	1.5	1.9
2nd Grade -----	5	2.9	3	1.5	2.2
3rd Grade -----	11	6.5	7	3.6	5.1
4th Grade -----	15	8.8	7	3.6	6.2
5th Grade -----	10	5.8	14	7.1	6.4
6th Grade -----	30	17.6	48	24.5	21.1
7th Grade -----	20	11.7	14	7.1	9.4
8th Grade -----	12	7.	7	3.6	5.3
9th Grade -----	12	7.	7	3.6	5.3
10th Grade -----	6	3.5	14	7.1	5.3
11th Grade -----	4	2.3	6	3.1	2.7
High School -----	21	12.2	37	18.9	15.5
College 1 year -----	1	.7	--	--	.4
College 2 years -----	--	--	2	1.	.5
College 3 years -----	--	--	--	--	--
College 4 years -----	4	2.3	5	2.6	2.4
	<u>171</u>	<u>100.0</u>	<u>196</u>	<u>100.0</u>	<u>100.0</u>

Table 6-B
Distribution of First Schizophrenic Admissions to Goldsboro Hospital
by Occupation Migration, and Duration of Disease
July 1, 1957, through June 30, 1958

Occupation	Male		Female		Average
	No.	%	No.	%	%
Migrants -----	2	0.85	2	0.98	0.91
Farming -----	35	20.5	10	5.1	12.8
Odd jobs -----	69	40.3	8	4.1	22.2
Skilled -----	37	21.6	8	4.1	12.9
Professional -----	4	2.3	8	4.1	3.2
Domestic -----	--	--	129	65.8	32.9
Unknown -----	8	4.7	11	5.6	5.1
None -----	18	10.6	22	11.2	10.9
	171	100.0	196	100.0	100.0
Rural -----	85	49.7	94	48.0	48.9
Urban -----	74	43.3	97	49.4	46.3
Unknown -----	12	7.0	5	2.6	4.8
	171	100.0	196	100.0	100.0
Duration of illness					
0-1 week -----	23	13.5	21	10.7	12.1
2-3 weeks -----	17	10.0	20	10.2	10.1
1-3 months -----	19	11.1	39	19.9	15.5
6-11 months -----	12	7.0	18	9.2	8.1
1 year or over -----	62	36.2	80	40.8	38.5
Unknown -----	38	22.2	18	9.2	15.7
	171	100.0	196	100.0	100.0

mother who got the better job on the plantation, working in the house, and had certain advantages over the husband. This situation remains to date. The Negro woman generally has a better chance for steady and sustained employment and is recognized as the responsible member of the family. This is especially true in the lower class (Frazier¹⁷). The Negro husband and father still plays a secondary role, and is usually regarded by the woman as unstable and unreliable.

These factors have a great influence on the growing Negro child. The mother, usually working, is burdened with respon-

sibilities and frustrated in her role. Besides rearing her own children, which are usually many, she has to work away from home in domestic jobs, often taking care of white children. Normally, a child shows an intense dependence upon his mother during his early development, but it is very difficult for the growing Negro child to achieve this interpersonal closeness. Cohen and others²² have pointed out that he is often unable to establish a mature relationship based on recognition of others as whole separate persons. He thus experiences frustrated dependency needs, with hostility toward the mother, and often suffers severe emo-

Table 7
Geographic Distribution

Diagnosis	Raleigh District			Morganton District		
	Total %	Male %	Female %	Total %	Male %	Female %
Involuntional psychotic reaction	4.1	2.3	2.	2.5	.6	1.9
Manic-depressive reaction	1.7	.6	1.	1.2	1.2	--
Psychotic depressive reaction	1.7	.6	1.	1.9	1.2	.6
Schizophrenic reaction	48.	22.	26.	58.4	28.	30.5

Table 7 shows the percentage of schizophrenic admissions to Cherry Hospital from the Raleigh-Morganton Districts.

Table 8
Education*

	Per Cent
Unknown -----	5.0
None -----	5.3
1st-5th grades -----	21.8
6th grade -----	21.1
Total -----	53.2
High School -----	15.5
College -----	3.3

*Abstracted from Table 6-A

tional deprivation, with lack of opportunity for self-expression and the formation of a positive self-image.

In interviews with Negro schizophrenic patients at Goldsboro, one is always impressed by the amount of frustration and hostility involved in talking about the mother. Also because of the above factors, the father is unable, being the weaker and more unstable member of the family, to give emotional support to the growing child. This results in hostility toward the father and authority figures in general. All this causes resentment toward the whole world, and especially the members of his own race, in whom he sees and hates his own image.

Ego ideal

The frustration and difficulties involving the self-image established in early childhood are intensified in the phase of

development wherein the child has to make identification. The Negro here is characterized by frustration as far as the ego ideal is concerned. Since his early upbringing the world for him has appeared hostile, and quite often he is unable to find a person to identify with. Even if he is able to identify with some important person in the white world, the identification is a hostile one.

This can be seen also in the delusions or hallucinations of the Negro schizophrenic. Here he usually imagines himself as a very important white person, such as the President of the United States or some other nationally known figure. There was only one male schizophrenic at Goldsboro who identified with a nationally known Negro boxer, and a few young patients who identified with Negro rock-and-roll singers. The importance of this factor is dealt with in a separate paper¹⁸.

Generally speaking, these dynamic forces are quite apparent in the growing Negro child, and the inner pressures lead to self-hate, depreciation, and a special concern as to skin color, body build, and social status, as pointed out by Bingham Dai¹⁹. For the Negro, especially the female, the shade of her skin is of great concern. She has much higher marriage value and chance for advancement if she is light-colored, while the male has more difficulty if he is lighter-colored than his mate.

It is believed that skin color among Negroes is related to prestige. Darker-skinned persons are seen as having lower status. For this reason a light-skinned child may very early develop hostile feelings toward a

dark-skinned mother, or vice versa. Very light-skinned Negroes, especially those who can pass as white, lose their sense of belonging to either race and become more and more alienated and hostile. If this happens in a family of dark-skinned persons, or if one member of a light-skinned family is dark, the pattern of difference is started so early that problems are inevitable. In the case of one light-skinned child in a dark-skinned family, the question of true parentage is sure to arise. Often such a child creates, through fantasy, a different father—commonly a prominent person, usually white. Our experience at Goldsboro has included an Eisenhower, home-town mayors, and the King of the Gypsies. This same kind of creation is noted in illegitimate children. The factor of color differences may explain the great number of paranoid teen-agers²⁰.

External factors

Besides his inner pressures, the Negro is subject to realistic external pressures specific for his race. His childhood and adolescence are cut short by the necessity of earning a living or contributing to the support of the family. He is forced to assume the responsibilities of survival at an early age, especially when the available jobs require little skill or education. [Wilson²¹ has also reported an increase in schizophrenia in the Negro because of segregation and the uncertainty accompanying cultural changes. As a result of these factors, it may be said that the lower class Negro family is extremely unstable and disorganized, providing a poor environment for the child's growth and development. He lacks the necessary sources of gratification, self-expression, and integration for normal growth and development. The special Negro family structure, especially in the lower classes, together with the interaction of interpersonal, cultural, and socioeconomic factors, are of great importance in the Negro's basic concept of himself. Under stress, many have to choose schizophrenia in order to avoid looking into the future, which is characteristic of the schizophrenic.

The early frustration and difficulty in establishing positive object relationships

may account for the high incidence of schizophrenia and the low occurrence of manic-depressive psychosis in the Negro. At Goldsboro only 9 cases were diagnosed as manic-depressive as compared with 25 at Raleigh and 46 at Morganton (table 2). As Cohen and others²² have pointed out, greater maturity is necessary for the development of manic-depressive psychosis. The Negro often is unable to develop a well integrated ego; instead it remains more or less immature and fragmented. In a personal communication, Dr. Helen V. McClean of Chicago, expressed the same beliefs.

Summary

The rate of first admissions of Negro and white patients to mental hospitals in North Carolina and the State of New York are compared. The rate of Negro schizophrenic admissions are significantly higher than white admissions in both states.

The majority of schizophrenic admissions to Goldsboro came from the lower socioeconomic level, and this is felt to be one of the causative factors in the high level of specific and basic frustration in the Negro.

Migration was a rare factor in North Carolina as compared to the State of New York.

It is felt that the genetic and dynamic forces stemming from his specific family structure exposes the Negro to great and frequent frustration from early childhood. These specific forces in the Negro, closely interrelated with cultural, interpersonal, and economic pressures, are stress factors and may be responsible for the higher incidence of schizophrenia in the Negro race.

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Treatable Organic Psychosis in a State Mental Hospital

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Dorothea Dix Hospital has been changing rapidly in the past decade. There are closer ties with the University of North Carolina, better cooperation with local physicians, and improvement in personnel. Both state and hospital administrations are attempting to develop the research potential of the hospital. Outpatient facilities and follow-up care of discharged patients are improving.

Through all these changes there is increasing emphasis on the function of the state hospital as a diagnostic center. Some physicians in North Carolina now rely on Dorothea Dix for diagnostic evaluation, as well as for the traditional functions of therapy and custodial care.

Review of Causes with Illustrative Cases

This paper is a partial review of treatable organic causes of psychosis seen at Dorothea Dix from July, 1959 to July, 1960. These are problems which will continue to occur in North Carolina and which can sometimes be managed without hospital commitment.

Infection

A 52 year old single woman became despondent after her stepmother died, leaving her alone with an irascible father. After several months of depression she became confused, then destructive and denudative. On admission she was thought to have a psychotic depressive reaction. She was disoriented at night and at these times stole the valuables of other patients. An electroencephalogram revealed scattered slow waves, but was within normal limits, and the colloidal gold curve was 5554430000. After being given 600,000 units of penicillin intramuscularly twice a day for 12 days, she was improved, and was discharged several weeks later with no indication of mental illness.

As every practitioner is keenly aware, the availability of adequate treatment for early syphilitic infection has not erased the disease. Among the patients who fail to get early treatment are those who appear to have a functional disorder. The treatment of central nervous system lues with penicillin has been well standardized¹, and a total of 6,000,000 units is ample. A Wassermann test is desirable in all mentally disordered patients, and is given to all patients at Dix on admission. A Wassermann test would

¹From Dorothea Dix Hospital, Raleigh, North Carolina.

seem equally desirable before commitment of mentally ill patients.

Except for lues, few infections have been the direct cause of commitment to Dix this year. Tubercular patients who are also psychotic are occasionally transferred here. At least one case of meningitis has been found on the admission ward, but the onset may have occurred after admission.

Trauma

Mettler and Crandell² report that the neurologic disorder most frequently missed in psychiatric institutions is brain trauma. Though trauma is particularly common on the chronic wards, unsuspected brain injury is sometimes present in new admissions. Often the injury is obscured by other factors, as in a recent confused and elderly woman admitted with a history of drug addiction and malnutrition. Hemiplegia developed in the patient soon after admission, and after her death two days later a huge subdural hematoma was discovered. A happier result occurred in middle-aged alcoholic whose condition deteriorated on the ward and who then recovered when bilateral subdural hematomas were removed by Dr. Horace Cupp in Durham, North Carolina.

Strassman³ has stated that at autopsy in a mental hospital 20 per cent of the patients past 60 had small subdural hematomas or membranes. Gross brain trauma is usually obvious at all ages, but even minor or unknown trauma may produce major brain damage in the aged patient.

Poisoning

This 50 year old part-time painter was hospitalized at an academic center for two weeks because of visual hallucinations, confusion, and intractable seizures. The spinal fluid pressure was 600 mm., and trephination was performed repeatedly for a suspected subdural hematoma. He was transferred to Dix with a diagnosis of alcoholic encephalopathy. On admission he was severely confused, and there was marked papilledema bilaterally. He manifested weakness of the right sixth nerve and increased reflexes in the left arm and leg. Babinski's sign was present bilaterally. There was a dark line on the gums, and basophilic stippling was noted in the red cells. An electroencephalogram was diffusely abnormal, with scattered slow waves. The blood lead

level a week after admission was 0.18 mg. per 100 cc. (normal, 0.01-0.06 mg.). The patient was given calcium disodium versenate, two tablets four times a day for 20 days, and was asymptomatic 30 days after admission. On discharge he spontaneously attributed his illness to white whiskey distilled through an old and frequently soldered automobile radiator.

In the past lead paint was a common source of lead poisoning. A more recent source in North Carolina is alcohol distilled through non-copper stills. Basophilic stippling, a lead line on the gums, signs of organic brain disease, and a high degree of suspicion are all helpful in making the diagnosis. Calcium versenate, a chelating agent which increases lead excretion, is indicated in most cases of lead intoxication.

Arsenic and bromide are two other metals which create medical problems in North Carolina. There have been only 2 recognized cases of arsenic poisoning at Dorothea Dix this year, and neither was severe. In the first six months of this year 6 patients were admitted with a serum bromide level of more than 200 mg. per 100 cc. An additional 9 patients had levels between 50 and 200 mg. per 100 cc. In no case was bromide intoxication mentioned on commitment papers, and apparently none of these patients had had bromides prescribed by local physicians. The most common source was Miles's Nervine, and occasionally Bromo-Seltzer and Neurosine. Salt and diuretics was the usual treatment of the patients with higher bromide values. All these patients recovered from bromism, although more than half required further treatment for underlying psychiatric disease.

Drug reactions

Approximately 10 per cent of the emergency psychiatric admissions, aside from drug and alcoholic commitments, are clearly related to a drug-included toxic state. Some of the most bizarre reactions are those related to phenothiazine derivatives. These drugs, particularly prochlorperazine (Compazine) and trifluoperazine (Stelazine), can produce anxiety, spasms of the neck and shoulder muscles, involuntary tongue movements, and even severe generalized dystonia. At least 2 patients with such reactions have been admitted here this

year, both with retroflexion of the neck and protrusion of the tongue related to prochlorperazine. Both cases had been diagnosed as hysteria before admission. This type of case is frequently reported in the recent medical literature; and treatment with caffeine, anti-parkinsonian drugs, or Benadryl is usually effective. In this, as in other drug induced neuropsychiatric disorders, the fundamental treatment is withholding the toxin.

Aging

Aged patients present a particular problem in view of the large number admitted (almost 400 a year) and the preponderance of general physical illness in this group. Most of the aged patients with organic brain disease have diffuse neuronal and cerebrovascular disease. Even if associated general disabilities are adequately treated, the majority of these patients never leave the hospital.

Unquestionably nutritional factors are still a feature in some admissions, though pellagra is now rare. Some of our elderly patients are malnourished on admission, with a smooth red tongue and moderate dehydration. Though routine laboratory tests are usually normal, on receiving vitamins and food these patients improve physically and mentally.

Another factor of definite but unmeasurable importance is decline in sensory function in the aged. About 4 out of 10 patients admitted to the senile ward have cataracts or decreased hearing, or both. Experiments on sensory deprivation in normal people have demonstrated the rapid development of psychosis with isolation from environmental stimulation. Many elderly people are separated not only from familial, social, and vocational environments but from the worlds of sight and sound as well. Nevertheless, it is difficult to prove that the mental status of these aged patients would be better if sight and hearing could be improved.

Newly admitted senile men frequently have a moderately elevated blood urea nitrogen. Since only one prostatectomy was done this year at Dorothea Dix, apparently

urinary retention and uremia is not a common cause of admission here.

For six weeks patients admitted consecutively to the male geriatrics ward had a lumbar puncture and skull roentgenograms in an effort to detect treatable central nervous system disease. These procedures were limited to patients with a diagnosis of organic brain disease, and appeared moderately fruitful in this small series (table 1).

Brain tumor

A 57 year old woman began to manifest withdrawal tendencies and mild confusion six months before admission. Emotional lability and some slowness of speech was present for two months. On admission she was depressed and lethargic. Routine physical examination was unremarkable. Repeat neurologic examination several weeks after admission revealed apathy, variable aphasia, and increased tone of the right arm. The cerebrospinal fluid protein was 88 mg. per 100 cc. An electroencephalogram was diffusely abnormal. A pneumoencephalogram revealed a mass on the left side, and Dr. LeRoy Allen removed a huge meningioma from the left frontal area and a smaller and completely separate meningioma from the left parietal area. She recovered uneventfully from the operation and returned home without symptoms or signs of disease.

Most psychiatrists are quickly alerted by symptoms suggestive of brain tumor, and are disturbed if a tumor is overlooked. General practitioners are also distressed by missing a tumor; though the social and personal significance of failure to recognize a depressive illness, for example, may be just as catastrophic to the patient. In most mental hospitals the size of Dorothea Dix, approximately one patient with brain tumor is admitted each month. In the past year, 9 have been seen at Dix.

Slow growing tumors, tumors in relatively silent areas (such as frontal lobes), and tumors in aged patients are the ones most likely to be found in admissions to a state mental hospital. Headache, vomiting, and papilledema are frequently absent. A long history and location of the tumor in a silent area would tend to indicate good surgical prognosis for many of these cases. A mistake in diagnosis is the only reason for admitting a patient with an untreated brain tumor to Dorothea Dix.

Table 1

Consecutive New Admissions to the Male Geriatric Ward

May 1, 1960 - June 14, 1960

Case	Age	Diagnosis	Skull Roentgenogram	Cerebrospinal Fluid	Comments
1.	78	Chronic brain syndrome with senile brain disease	Normal	Normal	
2.	66	Depressive reaction			
3.	79	Chronic brain syndrome	Normal	Protein, 58 mg. per 100 cc.	Previous stroke, pneumonia on admission
4.	62	Depressive reaction			
5.	72	Chronic brain syndrome with arteriosclerosis	Normal	Protein, 68 mg. per 100 cc.; slight xanthochromia	Possible subdural hematoma. Arteriogram showed anterior cerebral artery shift. Patient died but no autopsy was obtained.
6.	76	Chronic brain syndrome with senile brain disease	Normal	Protein, 91 mg. per 100; positive Wassermann	Syphilis not previously treated
7.	73	Manic-depressive psychosis	Normal		
8.	68	Chronic brain syndrome with arteriosclerosis	Normal	Normal	
9.	85	Chronic brain syndrome with senile brain disease	Normal	Normal	
10.	82	Chronic brain syndrome with senile changes	Head injury before admission	Protein, 65 mg. per 100 cc.	Died following hypotensive episode while in wheelchair. Cause of organic dementia unknown
11.	53	Chronic brain syndrome with metabolic disease, diabetes mellitus	Normal	Normal	Frequent insulin reactions. Massive left cerebral infarction, possibly related to internal carotid thrombosis
12.	76	Chronic brain syndrome	Normal	Normal	Stroke 6 months before admission

Table 1 (Continued)

13.	58	Chronic brain syndrome	Normal	Normal	Korsakoff's psychosis. Patient transferred from alcoholic service.
14.	58	Chronic brain syndrome associated with brain tumor	Pineal markedly shifted	Not done	Admitted to senile ward because of debility, not age. Died at operation
15.	70	Chronic brain syndrome with arteriosclerosis	Normal	Normal	Previous mild stroke
16.	83	Chronic brain syndrome with arteriosclerosis	Normal	Protein 59	No signs of focal cerebral disease
17.	70	Chronic brain syndrome with arteriosclerosis in remission	Normal	Refused	On admission was disoriented and confused following ingestion of sedatives
18.	62	Mild mental deficiency	Normal	Unsuccessful	Discharged soon after admission
19.	61	Severe mental deficiency	Normal	Normal	Diagnosis of abiotrophic ophthalmoplegia externa
20.	57	Chronic brain syndrome with arteriosclerosis	Normal	Protein 70	Massive stroke several weeks before admission for nursing care
21.	81	Chronic brain syndrome with arteriosclerosis	Normal	Not done	Left against advice soon after admission. Entered with moderate congestive heart failure
22.	69	Chronic brain syndrome with arteriosclerosis	Normal	Normal	Bremides 50 mg per 100 cc. several days after admission
23.	81	Chronic brain syndrome with arteriosclerosis	Normal	Normal	
24.	61	Chronic brain syndrome with arteriosclerosis	Normal (just before admission)	Normal (just before admission)	Bilateral strokes and pseudobulbar palsy
25.	63	Depressive reaction			

General medical problems

Occasionally patients are admitted to Dorothea Dix for a mental disorder which is only one symptom of a general medical problem.

Cerebral emboli: A 56 year old woman was admitted to another hospital for acute myocardial infarction and was transferred to Dix 18 days later because of progressive mental confusion. An electrocardiogram revealed changes of recent anterior infarction; the sedimentation rate was 43 mm. per hour, and the white blood cell count was 14,000. Neurologic examination and cerebrospinal fluid were normal. A few days later shock developed, the blood urea nitrogen was elevated, and the patient died after her temperature had risen to 108 F. Autopsy demonstrated arteriosclerotic nephritis, extensive infarcts of the heart, mural thrombi of the left ventricle, and embolic infarcts of the brain. She had never received anticoagulants.

Another patient was referred for treatment of peculiar behavior and persistent abdominal pain. The admission physical examination revealed ascites, an enlarged and apparently nodular liver, and edema of the legs. A biopsy of the liver revealed adenocarcinoma of undetermined origin. The patient was thus primarily a medical diagnostic problem and has been on the medical ward since admission. In the past year patients were frequently admitted directly to this ward for emergency diagnostic or treatment procedures.

Other organic conditions have been identified at Dorothea Dix this year, some of which are uncommon but treatable, such as pernicious anemia and hypothyroidism and hyperthyroidism. Probably other metabolic disorders or endocrinopathies are unrecognized even after admission. A larger number of patients were admitted with mental disease related to strokes, convulsive disorders, and birth injury. There is usually no question of diagnosis or of the need for admission of this group.

Comment

The large number of patients and the variety of problems they present indicate the necessity for extensive diagnostic facilities at state mental hospitals. The wide range of diagnostic problems also points out the continuing need for careful consideration

before patients are sent to a mental hospital.

The substantial percentage of patients with treatable organic disease admitted to Dorothea Dix Hospital poses two problems: (1) Is the diagnosis and care of such patients the proper function of a state mental hospital? (2) How can the percentage of such admissions be reduced?

Regarding the proper function of a state mental hospital, the answer depends upon the facilities, the citizens of the state, and the physicians of the state. Since the ultimate decision for commitment is often made by private practitioners of North Carolina, to a large degree admission policies of the hospitals are determined by the private practitioners.

Regarding the second question, the ideal way to reduce admissions for organic brain disease is to diagnose and treat such patients before deciding on admission. Of fundamental importance is the separation of organic from non-organic symptomatology. Confusion, difficulty with memory and judgment, decline in intellectual achievement, and shallow or inappropriate emotional responsiveness are all prominent in the organic syndrome. All these symptoms can sometimes occur with "functional" mental disorders, and the key to detection of organic disease in a psychotic patient is the alertness of the patient's physician.

In addition to a detailed history and examination, the following procedures are indicated in some cases of suspected organic disease before commitment to a state hospital: (1) Wassermann test; (2) skull roentgenograms; (3) lumbar puncture; (4) blood urea nitrogen; (5) test for bromides; (6) in special cases, several days of isolation from all drugs and from the family.

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Cervical Carcinoma — The Use and Abuse of Diagnostic Methods

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"The chance for recovery from cancer is inversely related to the extent of the disease when treatment is instituted; therefore, the early diagnosis of cancer is mandatory if good results are to be obtained."¹

In 1949 Lock and Caldwell recommended routine biopsy of every abnormal cervix. In their experience, this simple expedient improved early diagnosis to the degree that of all cases of cervical carcinoma detected, the number of Stage I and Stage II lesions increased from 33 per cent to more than 70 per cent. In the past decade, preinvasive squamous-cell carcinoma (carcinoma in situ) has been accepted as a distinct pathologic entity, and exfoliative cytology has become generally available as a screening method for cervical cancer. As a result, preinvasive and preclinical invasive lesions as well as occult endocervical lesions are being diagnosed with increasing frequency.

The efficacy of routine annual cervical smear studies has been confirmed by cancer survey programs. For example, in Columbus, Ohio, such a screening program reversed the percentages of clinical stages of cancer detected². Prior to initiation of the program, 86 per cent of all lesions detected were Stage II, III or IV, whereas after one year of screening, 86 per cent of lesions were Stage 0 (preinvasive) or Stage I. Of greater importance is the fact that in 73 per cent of the patients in whom cancer was found, the disease had not been suspected. In New York City³, exfoliative cytology utilizing direct cervical smears was the primary means of detection for 91 per cent of cancers found. All these lesions were preinvasive. The cytologic false negative errors were less than 10 per cent for a single

examination. Since this error becomes quite small with repeat examinations, it was concluded that when cervical cytology is included in an annual examination of cancer-free women, deaths from cervical carcinoma should be almost wholly preventable. Such has been the progress in early cancer detection, progress that far outweighs improved therapeutic methods of supervoltage radiation, chemotherapy, and radical surgery.

Preinvasive Carcinoma of the Cervix

Essential to the use of improved diagnostic methods is a full understanding not only of their interpretation and limitations, but also of the basic disease process in the cervix. By definition, squamous-cell carcinoma in situ is confined to the surface epithelium. Most often it arises at the squamocolumnar junctional area and may be present on the portio vaginalis and in the endocervix. Although tumor cells may extend into and replace endocervical glands, this does not constitute invasion. Regardless of their location, neoplastic cells completely replace the surface epithelium, but do not extend below the basement membrane into the underlying stroma. From indirect evidence^{3,4} it is quite probable that after a variable tenure in the intraepithelial location, the neoplastic cells do penetrate into the cervical stroma, becoming frankly invasive. It is not unusual to find invasive carcinoma surrounded by or interspersed with areas of preinvasive disease. Statistics indicate that preinvasive cervical cancer may be present up to 8 years before becoming invasive⁴. During this entire time detectable malignant cells are exfoliated.

If cervical smears are performed annually, the natural history of the disease provides latitude that should compensate for the low percentage of false negative cytologic errors, so that cervical carcinoma may

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be diagnosed while it is almost completely curable.

The Papanicolaou Smear

The superficial cells continuously exfoliated from vaginal and cervical mucosa may be evaluated very accurately by cytologic methods³. Considerable importance must be placed on the site from which smears are taken and on the method used. Comparative studies⁵ demonstrate that smears obtained directly from the cervix and endocervix yield the highest number of positive cells and are most valuable for the diagnosis of early lesions. Malignant cells are not present in the vaginal pool (posterior fornix) until later in the disease process, as indicated by a false negative rate of 22 per cent. However, since cells exfoliated from the vagina and endometrial cavity are usually present only in the vaginal pool, specimens should be obtained from all three sites in order to utilize the maximum scope of the method.

Cells may be recovered easily from the cervix by gentle 360-degree scraping of the squamocolumnar junction with a wooden spatula or tongue depressor, and from the endocervix by insertion and rotation of a cotton applicator stick. Since accurate interpretation depends on proper smear preparations, the following factors should be considered: (1) Smears obtained during a menstrual period contain blood and necrotic cells and few cervix cells; (2) a pre-examination douche removes the majority of exfoliated cells from the vaginal pool; (3) contamination with lubricating jelly prevents proper staining of the smears; (4) smears must be fixed immediately since drying obscures cytologic characteristics; and (5) smears obtained too soon after cauterization can contain abnormal cells regardless of the underlying lesion.

The following cytologic diagnoses are reported by our Department of Pathology and are representative. Class I and II smears include those with normal or atypical cells, and do not imply malignancy. Classes III, IV and V smears contain cells which respectively are suspicious for, suggestive of, and conclusive for malignancy. Class III smears may be recovered from

benign or malignant lesions. Malignant lesions have been found in up to 42 per cent of patients with such smears⁶. Class IV and V smears regularly are associated with pre-invasive or invasive carcinoma. These lesions, however, cannot be differentiated by cytologic examination alone. Reports of Papanicolaou smears are only cytologic diagnoses. Since the definitive diagnosis of malignancy requires histologic confirmation, *recovery of a positive cervical smear compels one to secure a tissue diagnosis.*

Conization of the Cervix

The cervical smear is an excellent screening technique because of its accuracy and broad scope. Exfoliated cells should be recovered from the entire portio vaginalis and endocervix. This broad scope presents a dilemma, however, when a positive smear is recovered from a normal-appearing cervix. If a chance focal or four quadrant punch biopsy fails to reveal malignancy, the entire squamocolumnar junction and adjacent cervix must be removed for step-section and histologic examination. Even if random biopsy, biopsy from a Schiller positive area, or biopsy of a gross lesion recovers a pre-invasive carcinoma, one cannot be assured that invasive cancer is not present until the entire cervix is similarly examined. To secure this tissue, knife conization of the cervix has evolved, not as a replacement for punch biopsy, but rather as a complementary method when punch biopsies are either inappropriate or inadequate. Unfortunately, this evolution of diagnostic procedures has been overlooked in the current trend toward diagnosis of grossly invasive lesions by conization. Often punch biopsy is bypassed for an unnecessary conization procedure.

Overenthusiasm for conization has had unfavorable sequelae. While the initial observer is in an ideal position to evaluate precisely the clinical stage of the malignant process, this opportunity is denied the therapist when conization intervenes. Moreover, removal of gross tumor often precludes one of our most important therapeutic guides—the tumor response to radiation.

Removal of an adequate cone of tissue

constitutes a considerable reduction of the total cervical tissue mass. Since adequate tissue mass permits more ideal local tumor radiation without overtreatment of the adjacent bladder and rectum, diminution of the cervical mass may complicate local radiation.

It has been demonstrated that invasive malignant lesions shed tumor cells into the circulating blood⁷. Moreover, local trauma or manipulation of a malignant lesion can cause a further showering of tumor cells into the blood stream⁸. Conization or dilatation and curettage is sufficiently traumatic to produce this effect and is a calculated risk when either is indicated. The procedure can hardly be justified under other circumstances.

Finally, total hysterectomy for preinvasive carcinoma performed within four months of conization is associated with increased febrile morbidity⁹. This possibility is unavoidable with carcinoma in situ. If radical hysterectomy for invasive cancer is elected after unnecessary conization, however, the morbidity is avoidable. In this instance, postoperative pelvic infection provides added insult to tissues partially devascularized by the operation. It may tip the balance toward ureteral or bladder fistulation.

Indications for Cervical Conization

From the above discussion it should be obvious that the very effective procedure of cervical conization should be reserved for those patients in whom specific diagnosis is otherwise unobtainable. With rare exceptions, we believe that knife conization of the cervix for the diagnosis of malignant lesions is indicated only in the following circumstances:

1. *After a punch biopsy diagnosis of carcinoma in situ.* Coexistent preinvasive and invasive carcinoma have been mentioned previously. If the former is discovered by punch biopsy, the remaining tissue is suspect for invasive cancer until it too can be examined. Cone biopsy of the cervix provides the only specimen adequate for excluding invasion. Therefore, *knife conization*

of the cervix is a prerequisite for the diagnosis of carcinoma in situ.

2. *For biopsy clarification.*

Cervical tissue obtained by punch biopsy or even by quadrant knife biopsy may be distorted sufficiently to make clarification between a preinvasive and an invasive lesion impossible. Cone biopsy provides the pathologist tissue for adequate section and tissue orientation.

3. *After positive cytology is recovered from a normal appearing cervix.*

If an appropriate site for biopsy is not evident, the diagnosis of an invasive lesion from random punch biopsy would be fortuitous. Since recovery of preinvasive carcinoma by punch biopsy necessitates conization in all cases, cone biopsy should be the initial and definitive procedure on the "clean" cervix.

Technique

These comments would be incomplete without some description of the conization procedure itself. The portio vaginalis and the adjacent vagina should be painted with Lugol's solution (Schiller test) prior to conization, and areas which fail to stain the normal mahogany color should be included in the cone unless the area of involvement is too extensive. The cone should include the entire squamocolumnar junction, at least a 0.5 cm. of the adjacent portio vaginalis, and the entire endocervical canal distal to the internal os.

The specimen should be excised by a scalpel or a similar cold cutting instrument rather than by the hot knife. The latter invariably causes coagulation of tissue which may interfere with histologic interpretation. These comments also apply to punch biopsy and to the control of bleeding from punch or cone biopsy beds. Bleeding can be controlled by simple pressure, oxidized gauze, or suture, and the tissue remains suitable for subsequent histologic examination if necessary.

Conization should be done in conjunction with and prior to dilatation and curettage. Initial dilatation of the cervical canal may strip away the only tumor present, especial-

ly the preinvasive variety. Similar caution should be taken not to traumatize the squamocolumnar junction. By this method an adequate untraumatized and undistorted cone biopsy can be obtained.

Summary

On occasion it is expedient that medical progress be reviewed and interpreted in its proper perspective. This is true of the Papanicolaou smear and cervical conization, since improved diagnosis of cervical carcinoma by the proper application of new methods may be negated by their improper use. Annual physical examination including a complete pelvic examination and cervical cytologic examination must be encouraged. Due thought must be given to the timing, site, and preservation of cervical smears. Cytologic diagnoses must be interpreted in the light of the natural history of the underlying disease process. Simple hysterectomy performed as definitive surgery for an isolated positive cervical smear or for preinvasive carcinoma diagnosed only by punch biopsy is blind treatment and may well terminate in disaster. Similarly, conization of the cervix may compromise further treatment when punch biopsy is adequate for definitive diagnosis.

It is hoped that these comments will

clarify thinking in one area of cancer diagnosis so that maximum benefit to the patient may be realized.

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When the early preparation is over, whether it be long or short, and this perplexed physician settles into practice he will need to worry about his patients. In fact, if he does not worry about his patients he is not likely to be a good physician. That does not mean that he should not play or have outside, even non-medical interests, or carry a lean and hungry look. The point is that when looking after a critically sick human being or even when the situation does not appear serious (for we often find out only later that a minor sign or symptom was the first tell-tale clue of some vital mortal process) we must constantly ask ourselves, "What may I be overlooking that is important."—Levine, S. A.: *Worry—Where Will It Get You?* *The Pharos* 23: 213 (Oct.) 1960.

Ruptured Aneurysms of the Abdominal Aorta

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Diagnosis, exposure, occlusion, resection, and grafting describe the surgical treatment of ruptured aneurysms of the abdominal aorta. This story has been repeated many times in the past 10 years, yet the reported successful results number less than a hundred. Many times the surgical treatment has been successful, but concomitant disease has resulted in a fatal outcome. The degenerative process which results in the aneurysm formation also leaves its mark on other vital organs which fail to recuperate from the shock of the retroperitoneal hemorrhage. The mortality rate in the surgical treatment of this condition is 33 per cent, according to DeBakey¹, yet it is 100 per cent fatal in the untreated cases. It is extremely rare for a ruptured aneurysm to "heal itself" and be followed by a long life span. Gliedman² has shown that 49 per cent of patients with palpable aneurysms die from rupture. Of those patients with aneurysms over 7 cm. in size, 80 per cent were dead within one year from rupture. The presence of an aneurysm, especially a large one, implies a short life expectancy.

One factor that favors the surgical treatment of a ruptured aneurysm is that 75 per cent of these aneurysms are located below the renal arteries¹. This allows cross-clamping of the aorta without the aid of hypothermia or perfusion to protect the kidneys. If the renal arteries or superior mesenteric vessel is involved, more elaborate and ingenious techniques are required. A second factor that aids the surgeon is a latent period between the onset of pain from initial rupture and total collapse. This period may be as long as 24 to 36 hours, but of course it is immeasurable and cannot be depended on to justify procrastination. Once the diagnosis is made, therefore, if surgery is to be attempted, no time should be lost in restoring blood volume and getting to work. The majority of these patients are old and are bad surgical risks; yet it is accepted that a minimum of preoperative preparation will

have to do, as too much delay may be fatal.

Case Reports

The following two cases illustrate the fact that judicial boldness may sometimes result in a successful outcome.

Case 1

A 65 year old man was first admitted to Moses H. Cone Memorial Hospital on April 14, 1959, with a 12-hour history of severe abdominal pain. Past history revealed that he had arrested pulmonary tuberculosis and suffered from chronic bronchitis and emphysema. Examination revealed an elderly man with a tender pulsating mass just below the umbilicus. There was abdominal rigidity and rebound tenderness. The blood pressure was 145 systolic, 70 diastolic. Hematocrit was 37 volumes per cent and the white blood cell count 23,000.

The diagnosis was not clear, but the patient was cross-matched for transfusion and the operating room notified. As the abdomen was being prepared for operation, he had a generalized convulsion and went into vascular collapse. Administration of Levophed was started and positive pressure transfusions were given for resuscitation. He was taken to the operating room, and through a long mid-line incision from xiphoid to symphysis the abdominal cavity was found to contain approximately 500 cc. of fresh blood, with a large hemorrhagic pulsating aneurysm lying at the pelvic brim (fig. 1). The retroperitoneal space was opened and approximately 1,000 cc. of clotted blood was found in both psoas areas. The entire abdominal aorta was laid bare past the ligament of Treitz, where the aorta appeared to be normal. The aneurysm, lying well below the renal arteries, was immediately freed from the vertebral column and clamped with a Satenski clamp. The iliac vessels at the inguinal ligaments were then isolated and clamped with bulldog clamps. From this point a more leisurely dissection of the hemorrhagic aneurysmal mass was done. The ruptured point was found to be just above the point of bifurcation on the left side into the retroperitoneal space. The aorta was removed completely, with the usual difficulty encountered around the vena cava and left iliac vein. The defect was repaired using a fabric graft of dacron. The upper anastomosis was carried out with running 3-0 black silk and the extremity anastomosis with a running 5-0 black silk. The aortic graft was functioning nicely following placement, and it was then reperitonealized.



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The anti-inflammatory and antipruritic efficacy of triamcinolone acetonide was shown by the prompt control of itching and resolution of affected areas. Cahn, M. M., and Levy, E. J.: A Comparison of Topical Corticosteroids: Triamcinolone Acetonide, Prednisolone, Fluorometholone, and Hydrocortisone.

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Figure 1

The patient tolerated the procedure quite well, receiving 9 pints of blood before and during the operation. Upon return to the recovery room, his feet were warm and there were good peripheral pulses throughout. His recovery was uncomplicated except for a slough on the medial aspect of the left leg caused by the Levophed drip. His urinary output was only 500 cc. for the first 24 hours and thereafter was normal.

After 28 days of hospitalization, prolonged mostly because of the slough on his calf muscle, the patient was discharged. At the present time, 24 months following his operation, he is fully ambulatory and asymptomatic.

Case 2

A 65 year old Negro man was admitted to L. Richardson Memorial Hospital, Greensboro, in November, 1960, complaining of severe abdominal pain which had been present for approximately three hours. The onset of pain had followed the ingestion of a barbecue sandwich. On admission his blood pressure was 220/110. Soon afterward the abdominal pain increased and the blood pressure collapsed. He became clammy, cold, and washed-out.

Examination revealed a pulsating aneurysmal mass in the lower part of the abdomen to the left of the umbilicus. Past history revealed that the patient had had an operation for hernia on the right and had been treated for high blood pressure for the past four years. Blood transfusions were administered under positive pressure and he was immediately transferred to the operating room at this hospital. With the systolic pressure still below 100, light anesthesia was administered and the abdomen was opened through a long midline incision. The abdominal cavity contained approximately 500 cc. of blood-tinged fluid and a hemorrhagic, pulsating mass was present in the aortic bifurcation, extending farther into the left gutter than into the right. The aorta above the aneurysmal mass, at about the point of the duodenum, felt normal. The re-



Figure 2

troperitoneal space was opened, and approximately 1500 cc. of fresh and clotted blood were aspirated as the abdominal aorta was exposed beneath the duodenum. By blunt dissection the aorta was freed from the vertebral column and inferior vena cava and clamped with a Satenski clamp. Positive pressure transfusions were rapidly administered and the blood pressure began to rise. The iliac vessels at the inguinal ligaments were isolated and clamped with bulldog clamps. At this point inspection of the aorta revealed that the aneurysm arose at the aortic bifurcation and primarily involved the left iliac artery, extending down to its tunnel beneath the inguinal ligament. The aorta was divided above, and by blunt and sharp dissection it was freed from the vertebral column and the inferior vena cava. Several patent vertebral arteries were found and ligated. The inferior mesenteric artery was patent but was divided. The aneurysmal mass was removed together with the hypogastric artery on the left.

The patient's general condition was quite good, and repair was accomplished by inserting a Dacron graft and anastomosing it to the aorta with running 3-0 black silk sutures. The iliac limbs were closed with running 5-0 black silk sutures (fig. 2). During the operation heparin was instilled into the distal femoral arteries to prevent the formation of fibrin clots. Upon release of the Satenski clamp good pulsations were felt down both legs. The entire sigmoid colon and mesocolon were hemorrhagic, but did not seem to be infarcted. The graft was peritonealized as well as possible and the patient, having received 8 pints of blood, was returned to his room in good condition.

The postoperative course was not complicated. During the first 48 hours the patient's urinary output measured 100 cc. and thereafter slowly regained volume. The blood urea nitrogen rose to 64, and he suffered some disorientation. There was an episode of diarrhea consisting of five to six loose stools a day on the seventh postoperative day, causing concern about the viability of

the sigmoid colon. This subsided, however, and the patient became fully ambulatory and was discharged on the fourteenth postoperative day. He has continued in good health and is fully ambulatory and asymptomatic at the present time.

Comment

The immediate availability of compatible blood and commercially prepared fabric grafts made treatment of these two cases possible. Transthoracic exposure of the aorta to insure control of hemorrhage has been recommended⁴. This was not done in either of these two cases, as it was not felt necessary. If the hemorrhagic area is disturbed too much, the normal aorta above the aneurysm can be isolated and controlled. This would not be possible, of course, if the aneurysm began in the area of the celiac axis. A thoracotomy adds tremendously to the surgical insult, and more often than not is unnecessary.

The use of heparin in the distal occluded femoral arteries seems logical in all cases. The oliguria demonstrated by these two patients is common to a majority of these cases, and undoubtedly reflects the diminished renal flow accompanying shock before surgical control of the hemorrhage is established. Indeed, many of the patients who have had successful grafts have expired because of renal failure in the postoperative period. Postoperative hemorrhage from the suture line in the anastomosis usually occurs from the first six hours to two weeks. These patients passed the critical period safely; however, delayed rupture into the duodenum with gastrointestinal hemorrhage has been reported many times, and may occur at any time up to several years after the operation. This happened more often with the use of homografts than with the fabric ones. Realizing the danger, we make every effort to re-

peritonealize the graft and keep the duodenum from lying in juxtaposition to the upper suture line. Thrombosis of the graft in these two cases is not expected, as both patients have good peripheral pulses, indicating a good "run-off" with patent vessels. The episode of diarrhea in case 2 suggested the probability of necrosis of the sigmoid colon, which has been reported in association with ligation of a patent inferior mesenteric artery when the aorta is resected for aneurysm. Fortunately this episode was short-lived and of no consequence. The presence of an occluded inferior mesenteric artery at the time of resection means that collateral circulation has been established; thus dividing it causes no worry.

Summary

Two cases of ruptured abdominal aortic aneurysms with successful surgical treatment have been presented. Several salient features concerning the management of these cases have been discussed, and an attitude of judicial boldness is recommended in the treatment of this otherwise fatal disease.

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The balanced career of teaching, research, and patient care no longer has the appeal that it had some time ago. One finds in searching for academic leadership that many of the most able young people are not available for the teaching appointments that come up and, if willing to take the appointment, look forward to getting somebody else to do the teaching and care of the patient.—Hinsey, J. C.: *Ingredients in Medicine Research—The Story of a Method*, *The Pharos* 24: 20 (Jan.) 1961.

The Limp in Childhood Due to Affections of the Hip

EULYSS R. TROXLER, M.D.

GREENSBORO

The problem of the limping child constantly confronts any physician who deals with children's diseases. Too often these patients reach us, as orthopaedists, with permanent disability which might have been avoided by earlier diagnosis and treatment. Any limping child should always be suspected of having a serious pathologic condition until proved otherwise. This symptom should never be dismissed as trivial or as "something he will outgrow." This brief discussion will include the more important affections of the hip from early childhood through adolescence.

Congenital Dislocation

The earlier the recognition or diagnosis of a congenital dislocation of the hip, the easier the treatment and the better the prognosis. It is of interest that the incidence is 85 per cent in girls as compared with 15 per cent in boys. It appears to be more prevalent in white- than in dark-skinned races, and may be familial. The incidence is higher in the Mediterranean area, especially among Italians. About 75 per cent of all cases are unilateral.

There are pathologic changes in the femoral head, the acetabulum, and the adjacent soft structures. The femoral head and neck are usually anteverted, although the reverse can be true. In unilateral cases the affected femoral head is smaller than that on the opposite side, and as time progresses the head may be flattened. The acetabulum is more shallow and its roof is more oblique. The capsule of the hip joint is pulled upward over the inferior part of the acetabulum, making reduction of the hip difficult. The ligamentum teres is usually elongated.

Congenital dislocation of the hip produces no pain in the infant. Subjectively, there is deformity or asymmetry of the hips and thighs. There is prominence and elevation of the greater trochanter on the affected

side. The creases of the inner thigh vary in number and location. This is more obvious in unilateral cases. There is shortening of the affected side, which can be measured from the anterior superior spine to the medial malleolus. Another way of observing this sign is to place the patient on the back, fully flexing the knees, with the hips flexed at 90 degrees. In this position, the knee on the affected side will be lower. In the anteverted cases, the femoral head can be felt anteriorly below the anterior superior iliac spine. More rarely dislocation of the head can be felt posteriorly in the region of the sacrosciatic notch. The thigh and leg may be atrophied on the dislocated side.

As a rule, the motion in a dislocated hip is not greatly limited. One of the most important signs is the loss of abduction when the hips are flexed. In the normal infant the thighs can be abducted about 90 degrees, but in the dislocated hip this movement is greatly reduced. A characteristic jog or thud can be felt as the dislocated head slips past the acetabulum while one is flexing and abducting the thigh. Piston mobility is demonstrated in true dislocation. This sign is pathognomonic of a dislocation or fracture of the femoral neck. In bilateral dislocated hips, the hips and thighs may appear symmetrical and equal in length, though careful examination usually demonstrates the above signs.

The diagnosis of congenital dislocation of the hip is much easier once the child begins to stand and walk. When weight is applied on the affected side, the opposite hip will drop, producing the Trendelenburg sign. The child walks with a waddling gait, swaying toward the affected side because of the shortened leg and unstable joint. In bilateral cases this abnormality may not be recognized as early as in unilateral cases. The "duck waddle" is typical of congenital dislocated hip, though other conditions can produce it.

Roentgenograms usually prove the diag-

nosis of dislocated hip. The 45 degree-angle views will help differentiate the anterior from posterior dislocations¹. On the affected side the femoral head is displaced outward and upward in relation to the acetabulum. As a rule, the head is underdeveloped. The acetabulum is more shallow and the roof more oblique. In the very young infant, these bony structures are not ossified and the defects are less easily recognized, though the upper femur and neck are displaced outward in relation to the opposite side. Roentgenograms will usually demonstrate telescoping by push and pull on the extended leg. In older children with untreated dislocations, the femoral head becomes flattened and may be seen opposite a false acetabulum in the wing of the ilium.

The diagnosis of a congenital dislocated hip is seldom confused with other pathologic conditions. Congenital coxa vara may produce limitation of hip motion and a similiar limp, but the piston mobility is absent. Roentgenograms differentiate fractures or suppurative arthritis of the hip. Rarely, dislocations may be present in neurologic conditions such as spina bifida or poliomyelitis, but in these cases the dislocation is secondary to motor weakness.

The treatment of congenital dislocated hips should be started in early infancy. It consists of gentle closed reduction and application of casts or braces. The position of the hip depends on the position of the dislocation or on the amount of anteversion of the femoral neck. Marked internal rotation of the femur is necessary in the latter cases. Osteotomy of the femur is frequently required to de-rotate it. Closed manipulation is usually successful before walking age. After this, open operation offers the most satisfactory result. The cast or brace is worn about three or four months, depending on the age of the child and the severity of the pathologic abnormalities about the hip. In cases where reduction is difficult, the complication of avascular necrosis of the femoral head may result. In children 5 to 6 years and older, reconstructive surgery such as the shelf operation is usually indicated.

Congenital Dysplasia

Congenital dysplasia of the hip is similar to congenital dislocation except that the pathologic changes about the hip are less advanced. The acetabulum is shallow or flattened owing to aplasia or hypoplasia of the roof. The extent of dysplasia varies greatly. Roentgenograms show an increase of the acetabular index and increased distance from the femur to the acetabular floor. Push and pull films do not show piston mobility. It is generally agreed that congenital dysplasia is the result of a genetic anomaly of the acetabulum, and that the instability and deformity of the hip are secondary². Another theory suggests that in unilateral cases an abduction-contracture of the opposite hip causes a tilt of the pelvis, thereby producing the dysplasia secondary to the adduction of the affected hip³. This abduction and external rotation of one hip and internal rotation and adduction of the opposite one are frequently seen from birth to about 6 months of age. The adducted side appears shortened and resists abduction into the usual frog position. Such cases can progress to dislocation if not treated.

Recently it has been shown that many cases of congenital dysplasia of the hip spontaneously return to normal without treatment⁴. During the first eight months repeat roentgenograms should be made to indicate the progress of development. If there is still evidence of dysplasia, the treatment consists of pillow splints or abduction bars to hold the extremities in corrected position. The length of this treatment varies with the time required for deepening of the acetabulum. Rarely such treatment may be needed for two or three years before the hip is normal.

Coxa Vara and Coxa Valga

Congenital coxa vara is usually first observed in early childhood, although it may not be recognized until later in life. In this condition, which is usually bilateral, there is a decrease of the angle between the femoral neck and the shaft by as much as half the normal 130 degrees. The condition is usually painless. The patient

has a "duck waddle" gait similar to that in bilateral dislocation of the hips. In spite of this gait, the hips are stable. Roentgenograms confirm the diagnosis. In more severe cases the treatment consists of osteotomy of the upper femur to correct the deformity. This procedure is done at about 6 to 8 years of age.

Coxa valga is a mechanical abnormality of the upper end of the femur, with an increase in the angle of the neck of the femur at its junction with the shaft. It is usually congenital. This condition produces a rather awkward gait, with the thighs outwardly rotated and abducted. As a rule, no definite treatment is needed except for adduction splints at night.

Coxa Plana

Coxa plana, also known as Legg-Perthe's or Calve's disease, is an affection of the hip usually occurring between the ages of 4 and 10. It is characterized by degenerative changes in the epiphysis of the femoral head, and runs a self-limited course. The cause is not known. Trauma seems to be an incidental factor, aggravating rather than initiating the condition. At no time has infection been proved a causative factor. The degenerative changes in the epiphysis of the femoral head are secondary to a circulatory disturbance. A connection with hypothyroidism has been suspected but not definitely proved.

In the early stages of the disease the synovial membrane, capsule, and periosteum are edematous and hyperemic. This change is followed by softening at the junction of the neck and the epiphyseal disc due to decalcification and increased vascularity. Dense areas soon appear in the femoral head, which are later invaded by blood vessels and granulation tissue. Areas of rarefaction develop, followed by some flattening of the head and femoral neck. As the disease abates, bone recalcifies and returns to normal except, in many cases, for some permanent flattening of the femoral head.

The most common symptom is a limp, which increases with the intensity of the disease. Pain is seldom severe. As a rule, the child complains of stiffness or aching

about the inner thigh and knee. Activity and exercise aggravate the symptoms. In the later stages, the limp may be secondary to shortening of the extremity.

On examination the limp resembles any other due to pain about the hip joint. Limitation of motion is best detected by immobilizing the pelvis and comparing the range of motion in the two hips. About 15 per cent of the cases are bilateral.

Laboratory findings are of little value, though in the acute stage there may be some elevation of the sedimentation rate.

In the earliest stage of the disease, roentgenograms may be within normal limits, although soon after the onset the epiphyseal line appears wider and more irregular than normal. Areas of increased density are then seen in the capital epiphysis. These areas become larger, and finally most of the head is involved. During decalcification, the head becomes mushroom-shaped, and the femoral neck thicker and shorter. Then the head is recalcified and normal trabeculations recur.

Any child between the ages of 3 and 10 complaining of limp and pain in the groin should be suspected of having coxa plana. If the roentgenograms are negative, the child should be put to bed until the physical signs disappear and repeat roentgenograms are normal. The diagnosis of coxa plana is seldom mistaken for septic arthritis, rheumatic fever, or tuberculosis. These diseases may be further distinguished by laboratory studies and other clinical features.

In the early stages, complete bed rest with traction is indicated. This treatment is usually continued for several weeks or until muscle spasm and pain have disappeared. Ambulant treatment consists of a leather sling holding the knee flexed at right angles. The sling is fastened to a shoulder strap, which is connected to a belt around the waist. Nonweight-bearing braces have been successfully used in some clinics. There has been very little proof that surgical treatment is of value. Full weight-bearing is deferred until roentgenograms reveal regeneration of the femoral head. This may be two to three years after the onset of the disease. The prognosis is excellent as far

as healing is concerned, although in adult life arthritic changes may develop secondary to the asymmetry of the femoral head.

Transient Synovitis

A common cause of limp in young children is transient synovitis. As the name implies, it is usually of short duration and seldom leaves permanent damage within the hip joint. Rarely, secondary structural changes such as those found in coxa plana may occur. The condition may be secondary to strain or injury of the joint, or it can follow infections in other parts of the body. Clinically, there is usually some tenderness about the anterior part of the hip. Muscle spasm with limitation of hip motion is constant. Treatment consists of bed rest with medication for pain. In most cases there is no reason for the use of antibiotics. Pyogenic arthritis, tuberculosis, and coxa plana should be considered in making the diagnosis of transient synovitis.

Slipping Upper Femoral Epiphysis (Adolescent Coxa Vara)

This is a disease of adolescence in which there is weakening and softening of the junction between the epiphyseal plate and the neck of the femur, usually resulting in displacement of the epiphysis downward and backward. The slipping usually occurs between the ages of 10 and 16 years. It appears more frequently in rapidly growing children and is a little more common in boys than girls. About 15 per cent of the cases are bilateral. The cause of the disease is not definitely known. Characteristically the patient is either unusually tall for his age or overweight, soft, and flabby. A history of trauma is often obtained, though the injury most likely causes slipping of the epiphysis which has been previously affected. There has been no proof of infection. Coxa vara is due to a circulatory disturbance about the epiphyseal plate of the femoral neck.

Slipping of the upper femoral epiphysis is divided into pre-slipping, slipping, and healing stages. The pathologic changes in the first stage consist of swelling of the synovial membrane and decalcification, with hypervascularity at the junction of the neck and the epiphyseal plate. In the

second stage, the head is displaced downward and posteriorly to a varying degree. Microscopically, there is separation between the neck and the epiphyseal disc. Degenerative changes are seen in the disc cartilage. After several months the healing stage becomes evident, with resulting scarring about the synovial membrane and periosteum or the femoral neck. Closing of the epiphyseal plate varies, depending on the age of the patient when the disease began. Where slipping has been marked, osteoarthritic changes usually follow in adulthood.

The symptoms of adolescent coxa vara, as a rule, are rather insidious and consist of pain, stiffness, and limping. The onset is usually slow. Pain is often referred to the knee. Even in acute traumatic cases there is a history of some pre-existing hip trouble.

Physical examination discloses a varying degree of limp with some external rotation of the lower extremity—or extremities, if bilateral. If much slipping has resulted, the rotation is quite marked. The affected thigh is often hyperextended. The shortening varies with the amount of slipping.

Laboratory tests are of little value. In the earlier stages the sedimentation rate may be slightly elevated.

Roentgenograms are of great help in making the diagnosis. Anterior and posterior views are of little value in early slipping. In anterior and posterior views the diagnosis may be missed because of the posterior displacement of the femoral head. Lateral views, however, with the hip flexed and abducted, show typical sliding of the femoral head. In advanced stages there is deformity of the proximal femoral neck, simulating a soft, bent candle. There may be complete displacement of the femoral head with only slight contact with the deformed neck.

The earlier the diagnosis, the better the prognosis. In pre-slipping and early slipping stages, weight-bearing on the affected side must be stopped. If there has been no slipping at all, this may be all the treatment needed. In early slipping, cast treatment or surgery is indicated. The operation consists of nailing the femoral head similar to

nailing a fractured hip. If the head has slipped one-third or more, an osteotomy just distal to the epiphyseal line is needed. Extreme care must be taken in this operation to prevent avascular necrosis of the femoral head. Treatment in any stage of coxa vara must be continued until there has been fusion of the epiphysis to the femoral neck.

In children, this important disease is often diagnosed as rheumatism or "growing pains." When the correct diagnosis is finally made, valuable time has been lost and there may be complete slipping of the femoral head. Any limping adolescent child should be suspected of having slipped femoral epiphysis. The outlook in early recognized cases is very good.

Pathologic Conditions of the Other Hip

The affections of the hip which have been discussed are by no means the only causes of limp in the infant and child. Time does not permit discussing such important diseases as pyogenic arthritis, tuberculosis, osteomyelitis, or joint tumors. It should be mentioned, however, that in pyogenic arthritis of the hip, aspiration of the hip joint does not replace adequate incision and drainage in all cases. Conservative care with antibiotics may decrease the temperature and improve the patient's general condition, but may not prevent increased pressure within the hip joint with resulting destruction of the epiphysis.

In acute osteomyelitis, massive doses of antibiotics have produced complete cure without destruction of bone. Incision and drainage still has a place in the treatment of this condition, but is not nearly as important as in acute pyogenic infection within the hip joint. Tuberculosis of the hip joint is now responding to drug therapy, whereas not many years ago extensive surgery with hip fusion was the routine treatment.

Summary and Conclusion

The symptom of limp in the infant and child must not be considered lightly. Every diagnostic means must be utilized in order to recognize the lesion early and thus avoid crippling disability.

Congenital dislocation of the hip can and should be diagnosed and treated before the

child reaches weight-bearing age. Congenital dysplasia is usually successfully treated with abduction splints or pillows. Repeat roentgenograms will help determine the treatment needed.

Moderate to severe coxa vara usually requires surgical treatment.

Some form of reduced weight-bearing seems definitely to decrease the residual deformity of the femoral head in coxa plana.

Transient synovitis is a common cause limp in children. Fortunately, it seldom results in permanent injury.

The diagnosis of slipping upper femoral epiphysis should be held in mind as the possible cause of limp in any child between the ages of 10 and 16.

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Report from The Duke University Poison Control Center

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Alkalies (Lye)

These corrosive agents are used in the manufacture of soap, chemical synthesis and in household drain pipe cleaning agents (lye, Drano, Pronto, etc.) They combine with protein to form proteinates and with fats to form soap, thus producing deep caustic burns on contact with tissues.

Symptoms are burning pain from mouth to stomach. Swallowing is difficult at first and then impossible. Mucous membranes are soapy and white, but become brown, edematous, and ulcerated; vomitus is bloody and may contain shreds of mucous mem-

brane. The pulse is feeble and rapid; respiration is rapid; collapse may ensue. Within weeks or months and sometimes years, esophageal stricture develops. Skin contact may produce first, second or third degree burns, depending on concentration of alkali and time involved. Eye involvement may cause severe conjunctivitis as well as corneal destruction.

In the treatment diluted vinegar, lemon or orange juice should be given immediately. Do *not* use gastric lavage or emetics. Olive oil or other demulcents ease pain. By the fourth day, and daily for two weeks, a rubber eyeless catheter filled with mercury or small shot should be passed into the stomach. The catheter size should be gradually increased until No. 32 or 34 enters easily. Dilatation should be continued periodically for at least a year. Seventy-five per cent of strictures can be prevented by this method.

The effectiveness of steroids which diminish fibroelastic activity in preventing esophageal stenosis after ingestion of alkali in rabbits suggested their use for the prevention of stenosis in children who have swallowed lye. Prednisone (10 mg. every six to eight hours) was administered for periods up to 16 days to 13 children who had swallowed lye, with Tetracycline to prevent infection. Neither infection nor stricture appeared in any of the 13 children. Skin contacts should be thoroughly cleaned with running water until skin is free of alkali as indicated by disappearance of soapiness. For chemical burns of the eyes produced by acid, the eye should be treated immediately by washing with water and with sodium bicarbonate solution (0.5 per cent). Alkali burns should be washed with water followed by a solution of 1 per cent acetic acid (vinegar, 1 part, and water, 4 parts). In burns elsewhere, dressings saturated with 2 per cent acetic acid should be used to complete neutralization of the alkali in the deeper tissues.

Chlorinated alkalies

There is a chemically nondescript group of chlorinated alkalies (or hypochlorites)

that pass under such familiar names as Javelle, Labarraque, Carrel-Dakin's, Clorox "chloro"—this and that, including "chlorinated lime," bleaching powder, and blanching or bleaching solution. By whatever name, the solution is extremely useful in the household and conveniently at hand for young children to explore and drink. The child is usually less than 5 years old, and with time on his hands, he finds the bottle of bleach under the kitchen sink or laundry tub. Even if he knew what "Poison" means on a label, as he cannot, housewives have an odd tendency to place the solution in some other container—a mayonnaise jar, a wine bottle, or even a baby's bottle. Once in a while the bleaching powder itself is swallowed. Ten per cent of the cases of household poisoning were due to these agents in one year's urban experience, and seem to be on the increase.

Of chief interest are the corrosive and caustic actions of the solution, which is fairly alkaline and liberates either chlorine or the putative "nascent oxygen" to decompose organic matter of various kinds. Thus, while it is splendid for killing organisms *in situ*, and as a deodorant, water purifier and bleach, it is harsh on the mucous membranes. It produces injury varying from irritation to chemical burns about the mouth, pharynx and larynx, and causes profound gastric inflammation. The damage is local; the material evidently cannot be absorbed as such, and systemic toxicity does not occur. But the damage can be quite serious with severe edema of the larynx and pharynx, intense gastritis, and rarely perforation of the esophagus or stomach.

Commercial bleaching solutions contain 3-6 per cent sodium hypochlorite (usually written NaClO), corresponding approximately to sodium hypochlorite solution N.F.; the dilute (surgical) solution is only 0.5 per cent, and even it is not used lightly. The chemistry of these substances defies explanation; it is said that they liberate chlorine when acidified, as in the stomach but they are actively corrosive as they come from the bottle. For treatment, see Alkalies above.

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NO VENDOR PAYMENTS FOR MEDICAL CARE GIVEN AGED INDIGENTS

An eventful call meeting of the House of Delegates of the State Medical Society was held in Durham on February 26. The chief purpose of the meeting was to approve or disapprove the recommendation of the Executive Council made two weeks previously that the Medical Society of the State of North Carolina should agree to participate in the Kerr-Mills Act providing medical care for aged indigents and that vendor payments for giving such care would not be accepted. In spite of a widespread wind and rain storm the day before and a rainy morning, there was a good attendance—132 delegates. After an invocation by Dr. George Paschal, President Amos Johnson and John Kernodle (Chairman of the Committee on

Chronic Illness) presented the case for participating without asking vendor payments. There was a free and full discussion before a motion to accept the recommendation of the Executive Council was adopted by a rising vote, almost unanimously. Then Dr. Hubert Poteat moved that the Kerr-Mills Bill be implemented in regard to ancillary services and drugs. This too was adopted without dissent, almost if not quite unanimously.

A second item on the agenda was to consider the formation of a corporation of the State Medical Society to control the Blue Shield program in the state, as recommended by an *ad hoc* Blue Shield Study Committee. This was quickly disposed of by a motion to refer the matter back to the *ad hoc* committee for further study and recommendations to the next meeting of the House of Delegates. A show vote indicated large support for a controlling and operating device.

The meeting of the House of Delegates adjourned shortly after one o'clock in time for most of the delegates to get back home the same day. Many were heard to comment that this was one of the most constructive and harmonious meetings of the House of Delegates yet held.

* * * * *

CHARLOTTE OBSERVER REPORTER WINS THE FIRST MEDICAL PRESS AWARD

A happy thought of the State Society's Committee on Public Relations was to offer an award for the best medical reporting by a North Carolina reporter, published in one of the state's daily or non-daily newspapers or periodicals. The first award for 1960 was given on February 11 at the Conference of County Medical Society Officers and Committeemen to Don Seaver, a reporter for the *Charlotte Observer*. Mr. Seaver was presented with a check for \$250 by Dr. Edgar T. Beddingfield, Jr., chairman of the Committee on Public Relations. The judges this year were Overton Jones, editorial staff, *Richmond Times Dispatch*; Dr. Donald B. Koonce of Wilmington; and W. J. Smith of Chapel Hill, editor of the *Charlotte Journal of Pharmacy*.

The award was given for quality and accuracy of medical reporting and not necessary for quantity. The criteria used for judging included journalistic style, research, accuracy of scientific content, and manner of presentation.

In making the award, Dr. Beddingfield called attention to the comment from one of the judges: "I have been impressed by the excellent medical reporting being done in North Carolina. The work done by the contestants in the Medical Press Award competition—and I'm sure by other North Carolina newsmen as well—is bound to be of benefit to the medical profession, the press and the public."

* * * * *

DO MEDICAL SCHOOLS EXERCISE BIRTH CONTROL?

In his best-seller, "The Status Seeker," Vance Packard expresses a misconception that is widespread. After granting that the M. D. degree is generally a badge of status, he charges that medical practitioners "have been exercising collective birth control on themselves." As proof, he says that "in 1900 there was one licensed doctor for every 578 people. By 1940, the proportion . . . had shrunk to the point where there was one for every 750 persons."

Mr. Packard—let us hope not intentionally, but at least conveniently—overlooked the fact that in 1900 there were more than 160 medical schools in the United States. Many if not more were mere diploma mills. The devastating Flexner report published in 1910—in which the A.M.A. heartily cooperated—resulted in over half of these going out of business. Now every medical school in the country is approved, and the number of graduates has been increasing for many years.

Mr. Packard also fails to give medical education credit for wanting to turn out competent doctors, but he should recognize that this accomplishment requires more than a desire for status. Medical leaders the country over are concerned over the decreasing number and lower quality of applicants for admission to our medical schools.

At its Clinical Session in December, the

A.M.A. House of Delegates adopted a scholarship and loan program "to attract increasing numbers of well qualified young people to enlarge the ranks of our profession." Would Mr. Packard consider this a birth control measure?

* * * * *

DR. EUSTACE SLOOP

Although the name of Dr. Eustace Sloop, who died February 6 at the age of 83, will not be found in *Who's Who*, he was one of North Carolina's greatest doctors and citizens. He had the distinction of having been graduated from two medical schools—the North Carolina Medical College (1905) and Jefferson Medical College (1908). After getting his diploma from the former and practicing for two years, he applied for admission to the senior class at Jefferson, was accepted, and graduated with the class of 1908. His tall figure and full beard made him one of the best known men in the class and his character made him one of the best liked.

He married Dr. Mary Martin, who was herself a physician and teacher, and they settled in Crossnore. They both had a vision of a school for the underprivileged mountain children—and by heroic efforts made this dream come true. The school they built has long been widely recognized. They also founded a hospital (Garrett Memorial). Dr. Sloop built a power plant by constructing a dam across the Linville River and rewiring an old discarded dynamo. Then he put poles in the ground and strung wires over them—first to the school, and then to mountain homes. All this was done in addition to carrying on an active general practice and looking after the community hospital.

His only daughter, Emma, is also a physician, and now is in charge of the hospital. Her husband, Dwight Fink, is principal of the school founded by her parents. The only son, Dr. Will Sloop, is a dentist and is practicing in Crossnore.

It is hardly too much to say that the lives of the Sloops will compare favorably in their complete dedication with such men as Dr. Albert Schweitzer. North Carolina has just cause to be proud of Dr. Eustace Sloop and his wife and children.

THE A. C. BULLA HEALTH CENTER

Dr. A. C. Bulla's long and fruitful service as health officer for Wake County was appropriately recognized by naming the new Wake County Health Center for him—the A. C. Bulla Health Center. The dedicatory service was held on March 5, when a tribute was paid him by Dr. Roy Norton, and his portrait was unveiled by his nephew, Kerry Niles Kesler. Dr. Bulla offered a few well chosen remarks, after which the building was presented by the architect, Mr. W. M. Weber, and accepted for Wake County by Ben Haigh, chairman of the County Board of Commissioners, and for the Wake County Board of Health by Mr. Fred Smith, chairman of the County Board of Health. After these remarks the building was open for inspection.

On the behalf of his friends, the NORTH CAROLINA MEDICAL JOURNAL sends congratulations to Dr. Bulla and the hope that he may live for many years to enjoy the tangible evidence of Wake County's appreciation for his faithful service.

* * * * *

THE NUMBERS GAME

This JOURNAL seldom quotes from the *Journal of the American Medical Association* or the *A.M.A. News*, because it is assumed that virtually all our readers see both these publications. The following quotation from the *A.M.A. News* is important enough, however, to justify making it an exception to the rule. It supplies the answer to one of the most widely quoted arguments for health care for the aged under Social Security.

THE OLD NUMBERS GAME

Proponents of health care for the aged under social security have based much of their argument upon this misleading statistic:

"... Three-fifths of all persons aged 65 and over had less than \$1,000 in money income in 1958."

This statement by the Department of

Health, Education and Welfare is insufficient and misleading without interpretation of the figures.

The data do not classify married women (supported by their husbands) in accordance with a proportionate share of their husbands' incomes, but rather by the amount of income directly received by the wife.

Thus, a married woman with no income of her own, whose husband has an income of \$10,000, is classified as having "less than \$1,000 in money income." In fact, zero income.

About 70% of the married women of all ages had zero income in 1958, according to this definition.

An appropriate measure of the aged's financial status, of course, should also include non-monetary income, assets, and other resources.

* * *

MICHIGAN STATE MEDICAL JOURNAL HONORS WILFRID HAUGHEY

For nearly 20 years Dr. Wilfrid Haughey has been the editor of the *Journal of the Michigan State Medical Society*. During this time his editorials have been models, and his conduct of the *Journal* has made it one of the most widely read and influential state journals.

It is quite fitting that the February issue of the *Michigan State Journal* should be "in tribute" to Dr. Haughey. It is also quite appropriate that the theme of the issue was medical writing, for Dr. Haughey is a master of that art. This particular issue was in preparation for more than a year, with Dr. J. P. Gray of the Parke-Davis staff in charge. Perhaps the best example of medical writing in the entire issue was Dr. Gray's guest editorial on "Wilfrid Haughey, M.D.—A Distinguished Editor." Dr. Haughey, over the many miles between us, this JOURNAL salutes you and fully concurs with Dr. Gray's conclusion that you are "a distinguished editor, an outstanding physician, a prominent citizen." Long may you flourish!

President's Message

PREPAYMENT MEDICAL CARE PROBLEMS

In this my last President's Message, it is fitting to evaluate for you your Society's position with relation to Blue Cross and Blue Shield prepaid insurance in this state. Much thought and considerable work has produced, to date, few results. Forces heretofore never allied for the same purposes have, without intent, become allied to the detriment of your Society's insurance plans. This makes for the interesting but discouraging narrative which follows.

Your House of Delegates, at my request, after much discussion and thorough understanding authorized an ad hoc committee on Blue Shield insurance to proceed with a plan to implement and expedite the formation and availability of adequate comprehensive Blue Shield insurance for our North Carolina citizens within realistic income limits. This project is of top priority importance in our effort to adequately cover the health care prepayment needs of our people and thereby produce a deterrent to federal socialization of the medical profession. The disconcerting but self-interested policy and action of our one Blue Cross and Blue Shield company, Hospital Saving, and our other Blue Cross company, Hospital Care, have served to prevent any real progress as to now.

Presently your Society, with slightly over 50 per cent of its membership participating, offers to the people of North Carolina one comprehensive (full payment) policy of Blue Shield prepaid medical service insurance, the "Doctor's Plan." The participating physicians underwrite the fiscal soundness of this policy by a signed agreement (contract) to supply services. Any deficit inherent is absorbed by the doctors. Conversely, any reserves accrued to this policy remain with the "Doctor's Plan" and do not accrue to the general reserve of the company (Hospital Saving) to be utilized at their discretion. Up to now very little of this comprehensive insurance (Doctor's Plan) is in force in North Carolina, nor is there evidence of conscientious effort on the

part of Hospital Saving to market this policy extensively.

Both Hospital Saving and Hospital Care market several plans of indemnity prepaid medical care insurance, which guarantee a certain amount towards payment of professional service charges rather than full payment of the bill, as do the comprehensive plan policies. The sale of the indemnity type policies is more profitable and efficacious to the company than is the comprehensive type policy, although they may not be to the best interest of the public in many instances. These companies may, within their legal corporate right, shift reserve monies within the framework of their single corporation between hospitalization and medical service policies to suit their needs and demands. Reserves accrued to comprehensive policies (Doctor's Plan) may not be so manipulated and must be reflected to the policy as (1) lower annual premium charges, (2) additional service coverage, or (3) increased payments for professional services rendered. This is not good for the vested interest of the company involved (Hospital Saving); consequently, few of these policies are sold. Thereby, the most important and needed phase of Blue Shield implementation is obstructed.

It became obvious to the leadership of your Society months ago that if comprehensive Blue Shield prepaid medical insurance were to be available to North Carolina citizens realistically, some changes must be made in Blue Shield policy in this state. Considerable investigation and mature thought evolved the plan whereby a new corporation (North Carolina Physicians Services, Inc.), subsidiary to the Medical Society of the State of North Carolina, should be organized to obtain and retain the Blue Shield emblem, formulate, underwrite the fiscal soundness, and implement the sale of comprehensive Blue Shield policies at realistic income levels in our state. It is visualized that these policies would be marketed, by agreement, as "fair trade"

items by insurance companies operating in this state, either non-profit Blue Cross companies, private enterprise insurance companies or both. Fiscal administration and processing of claims would be contracted to an agency adequate to perform this service. Thus, this Society would operate a live and functioning non-profit corporation supplying a real service to meet the medical needs of our people.

The Society has been given reasonable assurance by the National Blue Shield organization that the Blue Shield emblem now in the possession of Hospital Saving in this state would be made available to our corporation upon its implementation. The Society's retained legal counsel has drawn the papers of incorporation and the Executive Council has authorized the necessary action to complete this plan.

Now begins the confusion which has obstructed progress. It has become increasingly evident that the ultimate good of the people was not the motivating factor behind Hospital Care's urgent desire that this corporation be birthed immediately and come into possession of the Blue Shield emblem. Civil Service employees in this state obtain their prepaid medical care coverage under Blue Shield. Hospital Saving alone, having the Blue Shield emblem, carries this substantial body of insurance. Hospital Care, being excluded from this group, applied to the National Blue Shield organization last year (1960) to be allowed the Blue Shield emblem and participate in Blue Shield coverage in this state. This application was disallowed by National Blue Shield, for reasons sufficient, although our State Medical Society recommended that they be granted this emblem.

Hospital Care envisioned our proposed new corporation as a source of obtaining, by manipulation, the Blue Shield emblem for itself on an equal basis with Hospital Saving. People close to this company began a word-to-mouth campaign designed to have this new corporation within our Society become a "paper corporation" whose sole function would be to make available to Hospital Care the Blue Shield emblem which it was refused by National Blue Shield. The trans-

cribed proceedings of the House of Delegates of 1960 pertinent to this subject as discussed by Dr. Donald Stubbs, director of National Blue Shield, by me, and as evidenced by motion passed disavows this interpretation.

Hospital Saving has never thought well of the prospect of losing sole possession of the Blue Shield emblem in North Carolina. Although Hospital Saving is a non-profit organization whose sole justification for existence is to supply a service to North Carolina citizens, this company claims a vested interest in this Blue Shield emblem which presently is scarcely in keeping with the best interest of the people. Being aware of Hospital Care's attempted maneuver to obtain equally the Blue Shield emblem in this state, Hospital Saving, despite full knowledge of the real purpose of the new corporation, has offered active resistance to the Society's plan and has announced a plan of no cooperation should this new corporation be effected by the Society.

The National Blue Shield organization, upon learning of Hospital Care's interpretation of the new corporation, has told everyone that it would not alter its present affiliation in North Carolina to make the Blue Shield emblem available to a non-operating, non-active "paper corporation" whose purpose was to produce two companies having possession of Blue Shield emblem in this state. So now it becomes to the advantage of Hospital Saving to subscribe to the theory that the Medical Society plans a non-operating "paper corporation" with no real purposeful plan beneficial to the people of this state. We have made the circuit. The circle is completed and we are right back where we started.

If the citizens of North Carolina are to have access to realistic prepaid medical service policies from the two non-profit Blue corporations in our state, our Medical Society must take positive action. If realistic policies of this type are not made available within the immediate future to the citizens of this country, we may expect positive legislative action towards this problem on a national level.

There is reason to believe that our Society with its own corporation, answerable to the

House of Delegates, formulating policies, establishing professional service payment rates commensurate with premium rates on a realistic income level basis, can expect and obtain the cooperation of 85 to 90 per cent of its membership. I sincerely hope that the House of Delegates will, in Asheville this year, authorize and order the immediate implementation of this plan. National Blue Shield still indicates a desire to participate with us. Non-profit Blue Cross companies within this state may cooperate at their discretion. There is evidence that the private enterprise insurance industry desires to cooperate. The time to move is now.

AMOS N. JOHNSON, M.D.

Correspondence

VITAMIN SUPPLEMENT FOR HIGH SCHOOL STUDENTS

To the Editor:

I write with reference to the article by Dr. Frank E. Barnes, Jr., "Vitamin Supplements and the Incidence of Colds in High School Basketball Players: A Preliminary Report." Dr. Barnes is to be commended for his desire to investigate the possibility that vitamin supplements might benefit the health of high school students. He ends, "... it is believed that the vitamins definitely improved the health of the students. It is suggested that all high school students need multivitamin supplements, particularly during strenuous athletics in the fall and winter months."

Unfortunately, these conclusions are not justified in view of the design of the investigation. Undoubtedly the vitamin manufacturers are likely to quote Dr. Barnes' conclusions in their advertising. Again, we should be concerned about the possibility of unnecessary expenditure of money on vitamins by lay persons who are not qualified to interpret the meaning of such a report, and who may be unduly impressed by the conclusions. For these reasons the study needs to be redesigned and repeated.

A survey of the article leads to the follow-

ing essential comments. The 16 "other boys and girls of the same age and background as the players" who served as a "control group" unfortunately have one very great difference which was ignored in the study, namely, that they are not basketball players. It is possible that non-players would experience a different number of colds even if they had also been receiving a vitamin supplement. In fact they received nothing, not even a placebo. In any case, the common cold leads a fairly typical course and it is doubtful if the "colds" of one day's duration are the same kind of illness as those of longer duration. Certainly, the presence or absence of a cold is a very subjective factor which must not be left uncontrolled. Other factors include the official enthusiasm described by Dr. Barnes and possibly the day-to-day successes or failures of the teams. It is interesting to notice Dr. Barnes's statement that on one day 7 boys reported with colds following a "hard, rough game the night before, a circumstance that was repeated during the sixth week, when 6 players reported for practice with colds on a Monday, but no colds appeared during the rest of the week." Unfortunately, he does not tell us whether the teams were having a winning or losing streak at that time, but this might have important effects upon the incidence of illness.

All the variables can be fairly adequately taken care of by setting up a carefully controlled study using the double blind technique. It is for this reason that I am writing this letter, not in a spirit of criticism but in the hope that Dr. Barnes will feel encouraged to continue with his work and to repeat it under more scientifically rigorous conditions. A research study such as he is conducting is worth going to some trouble over as the results can prove to be most enlightening. With a minimal degree of assistance, it should be possible for Dr. Barnes to divide his basketball players randomly into two groups who would then receive coded vitamin supplements or identical-looking tablets of no therapeutic value, while neither the players nor those involved in evaluating the study are aware of which people are getting which prepara-

tion. A study of this sort would be open to accurate statistical evaluation and a most important publication would result.

In North Carolina there are three medical schools each with many workers (psychologists, biostatisticians, and others) who are qualified to help design a suitable controlled study. I hope that Dr. Barnes will avail himself of such assistance and I am looking forward to seeing a further article by him.

John A. Ewing, M.D.

Department of Psychiatry

University of North Carolina

* * *

(Dr. Barnes' reply to
Dr. Ewing follows.—Ed.)

Smithfield

Dear Dr. Ewing:

Your comments for a double-blind control study as well as a study done on a bigger scale are certainly worth while criticisms. This sort of thing I have in mind at the present time. I hope to go ahead next year with a study of the Selma and the Smithfield high schools, using one as a control. The study that I undertook at the Smithfield High School was done more out of curiosity than anything else, as I was quite curious about the actual benefits of vitamins on the general public or on growing students. I have been deluged with vitamin literature by the different drug companies, and when Squibb offered me sufficient vitamins to carry out this study I thought I would just follow it through and see if there was any advantage in this type of medication on a growing boy or girl. This study has already been criticized by the A.M.A.'s Council on Nutrition. They felt that a growing boy or girl does not need vitamins. They might be correct. But after the study that was done by the student nurses from the University of North Carolina on our high school students, I was quite convinced that these kids were not on an adequate diet that gave them all the necessary vitamins. We found that a great percentage of these children did not eat a balanced diet, and it is amazing that they can even exist on what they put into their stomachs. I am also convinced that the two sessions of supposedly sore throats or colds that happened on two different oc-

casions were nothing more than evidences of fatigue, as the symptoms disappeared so quickly. I suppose that an ideal study at the present time would be to give the children in the gym classes the vitamins and keep the high school basketball athletes on just the regular diets they receive at home. If I can get the cooperation of the school officials and the parents, I certainly intend to follow up this sort of study as I think it is worth while and will either condemn or show the need for vitamin supplements to our growing high school students.

I am not sure whether vitamins are doing these kids any good or not, but they seem to get through school very well, without colds, and our girls just won the district championship. I would welcome any further investigations by people at schools such as the University of North Carolina or at other high schools. I hope that somebody else will pick this up and continue the study. I know that several of the universities have their athletes on vitamins. Ohio University had their basketball team on vitamins when they went to the National Championship last year. There has also been a study done at the Naval Academy where it was found that huge doses of vitamin C have cut down the incidences of bruises on the football players. All these things will have to be investigated further before we come up with a definite conclusion and I hope that the vitamin distributors will not take advantage of this article to try to impress the public that everybody needs vitamins. Certainly the doctors have been deluged with this kind of thing and I am sure they will not swallow the whole article as a final conclusion.

Frank E. Barnes, Jr., M.D.

* * *

PAYMENT TO PHYSICIANS UNDER THE KERR-MILLS ACT

To the Editor:

I am writing this to call attention of the membership of the Medical Society of North Carolina to an event quite pertinent to the action taken by the House of Delegates at the called meeting February 26, 1961.

On February 28 there appeared in the newspapers a report of remarks made by Dr. Blasingame, Executive Vice President

of the A.M.A., in support of the Kerr-Mills Act as opposed to the Kennedy Bill. I am enclosing a clipping of this report as obtained from *The Virginian-Pilot*. You will note that Dr. Blasingame makes a special point of the fact that Kerr-Mills provides for FULL medical care to the needy aged as opposed to the Kennedy plan. He further specifies that physicians and specialists services are provided for.

I think we must assume that the mass of the reading public throughout the State of North Carolina will have read this report and will no doubt presume that the North Carolina legislature in preparing legislation implementing the Kerr-Mills Act will include provisions for full payment for medical care.

The Hertford County Medical Society asked me to serve as their delegate to the February 26 meeting and requested that I support the establishment of an equitable fee schedule for payment of physicians and specialists providing care. We felt that it would be possible for the North Carolina Society to negotiate a satisfactory fee schedule with the designated administrative agency of the Kerr-Mills Act in North Carolina. As you know, this proposal was overwhelmingly defeated by the House of Delegates.

The House of Delegates in its action on Sunday is denying to the needy aged of North Carolina the benefit of full medical care. A great point was made of how provision for payment of physicians would cause further deterioration of public relations of medical doctors. The vast majority of the delegates decided that it would be better for doctors to bill the patient directly for services rendered. We ought to realize, however, that when a person has been authorized to obtain medical care under the provisions of whatever law is finally passed by the North Carolina Legislature, he is not going to be very happy with the doctor who tells him to haul out his wallet and from his own personal resources pay for services rendered. He will be especially unhappy now that he has been lead to believe by widely published statements of A.M.A. leadership that payment of his doctor is

provided for. I fail to see how this will improve our public relations.

Let us assume that the North Carolina Legislature passes a law providing medical care for the needy aged and omits any provision for payment of physicians. The Legislature now has proof that this is in accordance with the wishes of the vast majority of North Carolina doctors. I think it is safe to predict that there will be strong public reaction against doctors billing this group of patients for services. Because of the action of the House of Delegates, this will be a reaction against us and not against the Legislature.

It was argued that if the doctors of North Carolina cooperated with this government plan for providing full medical care to the needy aged we would be fostering socialized medicine. This is no doubt true. The North Carolina Medical Society is glaringly inconsistent, however, when it refuses to negotiate an equitable Act and at the same time continue to approve of negotiated fees under other government medical care programs such as MEDICARE, VA Home Care, North Carolina Industrial Commission, Vocational Rehabilitation, etc. To be consistent, we should immediately invalidate all such contracts and return to a private fee basis in providing care to these special groups.

Edward T. Viser M.D., President
Hertford County Medical Society

Value of Hypaque Cited In Brachial Arteriography

The diagnostic efficiency and safety of retrograde brachial arteriography, performed with the contrast agent Hypaque in 200 patients, is described by Dr. Robert A. Kuhn in the *Journal of Neurosurgery* (17:955, 1960).

There were no cases of morbidity or death in a series of more than 200 brachial angiograms in adults and children.

It is pointed out that the method requires little time and has been accompanied by far less discomfort to the patient than percutaneous cervical puncture. Dr. Kuhn suggests that retrograde brachial arteriography be performed, in preference to percutaneous techniques, in three categories of patients. These are: patients for whom right carotid percutaneous puncture would be planned; patients requiring vertebral angiography; and as an integral part of total survey of the cerebral circulator ysystem.

Committees & Organizations

TRUST STUDY COMMITTEE*

THE KEOGH BILL AND THE MEDICAL SOCIETY

The Medical Society of the State of North Carolina has given attention to the Keogh bill (H. R. 10) type of legislation since 1957, when Dr. William A. Sams called it to the attention of the House of Delegates. In 1959 President Lenox Baker appointed a Trust Study Committee, *ad hoc* to the Finance Committee, to follow this proposed legislation and to advise on the feasibility of the Society's sponsoring a retirement plan under it for the benefit of the members.

In May, 1960 the committee presented a preliminary draft of a proposed North Carolina Medical Retirement Savings plan which would comply with the proposed legislation at that time. The House of Delegates adopted a resolution in May, 1960, which would allow the committee to negotiate with banking and insurance institutions to implement the provisions of any retirement benefit legislation, if and when such legislation was enacted. The president of the Society would also be authorized to execute, on behalf of the Society, a trust agreement with banking and insurance institutions.

H. R. 10 was not passed by Congress in 1960, but has been reintroduced in 1961 with the same H. R. 10 number. The new bill incorporates some of the provisions of the previous one, but has been changed in other ways. As far as the individual physician is concerned, these changes are not substantial.

When the Keogh Bill is finally passed, a large number of plans and programs will be available in which self-employed individuals can participate. It is anticipated that most large insurance companies will offer retirement programs which will be tied in with life or disability insurance. Also, large banks will operate a common trust fund in which self-employed individuals may participate by the purchase of units in the fund.

A number of medical organization now have in operation plans which can be adapted to obtain the benefits from the Keogh

legislation. The committee has studied the plans of the medical societies of Colorado, Florida, Canada, the American Academy of General Practice, and the American College of Obstetrics and Gynecology.

Participation in a large state-wide plan seems to hold definite advantages over participation in one of the many smaller plans on an individual basis. Generally, the trustees' charges for operating these funds decrease as the size of the fund increases. Also, the investments in a trust fund particularly designed for physician participants would be different from those in a fund designed for widows and minors. The fact that the income from the trust fund would not be taxable would also have considerable bearing on the placement of principal by the fund. In the purchase of annuities with a guaranteed fixed income, a society plan holds a definite advantage because of the special rates made for the society.

It is recognized that every physician will have his own ideas about the best way to provide for his retirement. However, the Trust Study Committee is planning to recommend to the House of Delegates that a plan for this Society be provided for those who wish to participate in a plan especially designed for physicians.

What's The Score?

During the first ten months of 1960, accidents claimed the lives of 2174 North Carolinians, according to data released by the Public Health Statistics Section of the North Carolina State Board of Health. This is a slightly greater toll than for the corresponding ten months in 1959, when there were 2,121 deaths from all accident causes.

Motor vehicle accidents accounted for 1030 deaths; home and farm accidents, 670 deaths; all other accidents caused 474 deaths during the ten-month period in 1960.

Life Insurance Medical Research Fund

Dr. William A. Jeffers, associate professor of medicine in the School of Medicine of the University of Pennsylvania, and an authority on the surgical treatment of hypertension, will become scientific director and executive officer of the Life Insurance Medical Research Fund, it was announced recently by the fund's board of directors, meeting at the Sheraton East Hotel, New York City.

*Dr. Jesse Caldwell, chairman.

Bulletin Board

COMING MEETINGS

Medical Society of the State of North Carolina, One Hundred Seventh Annual Session — Battery Park and George Vanderbilt Hotels, Asheville, May 6-10.

North Carolina Heart Association — Robert E. Lee Hotel, Winston-Salem, May 24.

Mountain Top Medical Assembly — Waynesville, June 22-24.

Seaboard Medical Association of Virginia and North Carolina — The Carolinian Hotel, Nags Head, June 16-18.

American Society of Internal Medicine, Annual Meeting—Eden Roc Hotel, Bal Harbour, Florida, May 6-7.

Virginia Academy of General Practice, Annual Scientific Assembly—Sheraton Park Hotel, Washington, D. C., May 11-14.

American Medical Association, Annual Meeting — New York City, June 26-30.

NEW MEMBERS OF THE STATE SOCIETY

The following physicians joined the Medical Society of the State of North Carolina during the month of February:

Dr. Thomas Edgar Ross, 104 S. Randolph St., Rockingham; Dr. George Washington Galloway, Jr., Hamlet Hospital, Hamlet; Dr. Roy Venden Berry, 69 Circle Drive, McCain; Dr. Harry Lester Johnson, Jr., Eastern Rowan Medical Center, Granite Quarry; Dr. Bobby Maxwell Foster, 717 Hospital Drive, Mocksville; Dr. Robert Bruce McQueen, 214 Marshall St., Graham; Dr. Robert Yuddell, 440 Halstead Drive, Charlotte; Dr. Jeanne Marie Valtaggio Sing, 2601 Woodbrook Lane Charlotte; Dr. Donald Benjamin Hackel, Duke University Medical Center, Durham; Dr. William P. Wilson, Duke University Medical Center, Durham.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. William H. Boyce, professor and chairman of the Department of Surgery's section on urology, participated in a Medical College of South Carolina postgraduate seminar, February 23. He spoke on "Urinary Factors in Stone Formation" and led discussions on the same topic.

* * *

Dr. Harold D. Green, Gordon Gray Professor of Physiology, has been named to the scientific council of the Institute for Advancement of Medical Communication, an organization devoted to

the development and explorations of new methods and media for transmitting information within bio-medical professions.

* * *

On February 7, Dr. Frank R. Lock, professor and chairman of the Department of Obstetrics and gynecology, spoke on "Rubella in Pregnancy" at a meeting of the Buffalo Obstetrics and Gynecological Society. On February 20, Dr. Lock spoke on his rubella studies to the faculty and house staff of the University of Maryland School of Medicine.

* * *

Dr. Isadore Meschan, professor and chairman of the Department of Radiology, served as instructor in the radiology section of the Armed Forces Institute of Pathology from February 27 through March 3.

* * *

Dr. Martin G. Netsky, professor and chairman of the Department of Neurology, has been named an assistant examiner for the American Board of Psychiatry and Neurology.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. Oliver Lowry, professor of pharmacology at the Washington School of Medicine in St. Louis, Missouri, was the sixth Lee B. Jenkins Lecturer at the University of North Carolina School of Medicine on February 22. He spoke on "The Chemical Structure of the Retina."

The lecture is an annual event established through the Lee B. Jenkins Endowment in 1954 by Mrs. Jenkins in memory of her husband, a prominent civic-minded industrialist of Kinston.

* * *

The chairman and two members of the Department of Obstetrics took part in the Atlanta meeting of the South Atlantic Association of Obstetricians and Gynecologists, February 15-18.

Dr. Robert A. Ross, professor and chairman of the department, discussed aspects of a caesarean section during the group's twenty-third annual meeting, while Dr. Leonard Palumbo, Jr., associate professor in the department, presented a paper the same day entitled, "Palliation in Gynecologic Cancer" during the meeting's third scientific program.

While in Atlanta, Dr. Ross also engaged in discussions at the Regional Conference on Perinatal Mortality and Morbidity being held by the American Medical Association, under the sponsorship of the Committee on Maternal and Child Care of the Council on Medical Service.

* * *

A grant of \$229,440 for a special five-year training program in genetics research has been awarded the School of Medicine by the U. S. Public Health Service.

Dr. John B. Graham, professor of pathology,

will be the director of the program, which became effective March 1.

* * *

Convulsive Seizures in children was the topic discussed at North Carolina's Seventh Annual Conference on Children with Special Needs on March 2 at the University of North Carolina Memorial Hospital.

Dr. William P. Richardson, assistant dean of the School of Medicine and chairman of the Coordinating Committee on Children with Special Needs of the North Carolina Health Council was planning committee chairman of the conference.

* * *

Dr. Thomas W. Farmer, professor of neurological medicine, moderated a panel on "North Carolina and the Epileptic". Members of the panel were Dr. Bluma B. Weiner, Coordinator of Special Education of Woman's College, U. N. C.; Dr. Robert R. Huntley, director of the General Practice Residency Program, School of Medicine; Miss Euzelia Smart, chief of Social Service, North Carolina Memorial Hospital; F. Kent Burns, Assistant North Carolina Attorney General; Dr. C. B. Kendall, Director, Crippled Children's Section, North Carolina State Board of Health; and Charles H. Warren, Director of Vocational Rehabilitation, North Carolina Department of Public Welfare.

* * *

Dr. Charles E. Flowers Jr., associate professor of obstetrics and gynecology, has been elected to the National Executive Committee and the National Board of Directors of United Cerebral Palsy.

Dr. Flowers is president of United Cerebral Palsy of North Carolina. Much of his research has been in the field of injuries associated with the birth process.

* * *

Among five veteran professors of the University of North Carolina scheduled to retire July 1 is Dr. W. Critz George, professor of anatomy.

Dr. George, a noted specialist in comparative studies of the blood of invertebrate animals and man, is a native of Yadkin County.

He first taught at the University in 1912 upon receiving his Masters degree in zoology here. He later received his Ph.D. in 1918, and taught at Guilford College, the University of Georgia, and the University of Tennessee before returning to the University.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF PUBLIC HEALTH

CHAPEL HILL—A public health problem which would require an engineer several days of work was solved recently by a Univac machine at the University of North Carolina Computation Center in one minute.

The demonstration was staged by Dr. John

W. Carr III, director of the Computation Center. Dr. Carr lectured and demonstrated the giant "electronic brain" before faculty members and students of the Department of Sanitary Engineering of the School of Public Health.

The problem was posed by Dr. Charles Weiss of the School of Public Health, and dealt with pollution of rivers.

The public health professor turned over to Dr. Carr certain data involving measurements of oxygen in a stream, plus measurements of the oxygen content of the water at regular intervals. After the material was prepared for the machine, the actual computation of future stream pollution, or lack of it, was available in one minute. This problem, if done by an engineer with a desk calculator, would have taken several days.

Such problems as this one are vital to the industrial growth of North Carolina. New factories are discharging increasing amounts of waste matter into streams. At the same time, pure water is one of the most essential factors in the industrial development of a state or a region.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

The old saying, "cold hands mean a warm heart" has taken on a new twist at the Duke University Medical Center.

Looking for better ways to treat cancer, Duke surgeons have developed a method in which the patient's over-all body temperature is reduced some 10 degrees Fahrenheit below normal while at the same time, his abdominal area is heated to a fever temperature of around 102 degrees.

Dr. W. W. Shingleton, Duke professor of surgery who headed development of the technique, said that this combination of high and low temperatures permits a safer and more effective use of anti-cancer chemicals.

While procedures for lowering and raising body temperature have previously been employed by surgeons, the Duke development is believed to mark the first time that the two techniques have been used simultaneously in the same patient undergoing cancer chemotherapy.

Since anti-cancer chemicals work better at higher temperatures, surgeons hit upon the idea of warming the drug-carrying blood. One of the pioneers in the "hot blood" technique is Duke neurosurgeon and Medical School Dean Barnes Woodall, who first used it for treating cancer of the head and neck.

When applied to cancer of the abdominal or pelvic areas, however, the method presents a problem, Dr. Shingleton said, "because it is extremely difficult to isolate the blood circulation of this region from the rest of the body's circulatory system."

The Duke surgeon and his associates turned to hypothermia (lowered body temperature) as an answer to this problem.

"Essentially, what we do is lower the patient's temperature from a normal 98.6 degree F. to around 87.8 degrees by use of cold blankets," Dr. Shingleton explained. "At this temperature, the blood becomes more viscous (thick) and the toxicity (poisoning effect) of anti-cancer drugs is reduced. Simultaneously, the surgically isolated blood supply to the abdominal area is heated by means of a special heat exchanger developed at Duke, and the anti-cancer drugs."

* * *

A new international scholarship has been established to permit British medical students to visit the Duke University Medical Center for three-month periods, Dr. Barnes Woodhall, dean of the Duke Medical School, announced recently.

The scholarship will be financed jointly by the British Medical Student Association, the Duke Chapter of the Student American Medical Association, and the Duke Medical Center.

One British medical student will be selected annually to spend three months at Duke studying a clinical subject such as surgery, medicine, pediatrics, psychiatry or obstetrics.

* * *

How do victims of accidental facial disfigurement feel about their loss, and how can they be helped most effectively?

Research designed to throw light on these questions is in progress at the Duke University Medical Center.

Prof. Elon H. Clark, head of the Center's Department of Medical Art and Illustration, is directing the study under a grant from the Office of Vocational Rehabilitation, U. S. Department of Health, Education and Welfare.

The project is centered on finding ways to produce better artificial ears, noses and other parts of the face that may be lost through injury or disease, Professor Clark said.

It is also concerned with evaluating the psychological effects of facial disfigurement, before and after cosmetic restoration, in order to provide for more effective rehabilitation of patients.

NORTH CAROLINA HEART ASSOCIATION

The North Carolina Heart Association will hold its annual Scientific meeting at the Robert E. Hotel in Winston-Salem on May 24.

Speakers and subjects will be as follows:

Morning Session

10 a.m. to 12:15 p.m.

Dr. Samuel Mellet, University of Pennsylvania

Diagnosis of Heart Arrhythmias

Dr. George Morris, Baylor University

Renogenic Hypertension

Dr. Irvine Page, Cleveland Clinic

Pathogenesis and Treatment of Hypertension

Afternoon Session

2 p. to 5 p.m.

Dr. Mellet

Treatment of Heart Arrhythmias

Dr. Morris

Extracranial Cerebral Vascular Lesions

Dr. Page

Atherosclerosis

Clinicopathological Conference: Dr. Eugene A. Stead, Jr. of Duke University Medical Center and Dr. Robert Prichard of Bowman Gray School of Medicine.

NEWS NOTES

Dr. Frank E. Pollock of Winston-Salem has announced the removal of his offices from the Nissen Building to 207 South Hawthorne Road. His practice is limited to orthopaedic surgery.

SOUTH CAROLINA MEDICAL ASSOCIATION

The One Hundred Thirteenth annual meeting of the South Carolina Medical Association will be held at the Francis Marion Hotel, Charleston, South Carolina, April 25-27. The program will include the usual business meeting, and a scientific program which will be presented largely by members of the faculty of the Medical School of the University of North Carolina.

Speakers will be Dr. James F. Newsome, Dr. Herbert S. Harned, Dr. William B. Blythe, Dr. A. Stark Wolkoff, and Dr. Charles A. Bream. Speakers from South Carolina will include Drs. Frank F. Espey of Greenville, Peter Gazes, and Wendell Thrower, both of Charleston.

ASSOCIATION OF AMERICAN MEDICAL COLLEGES

Thirty junior and senior medical students from across the nation were named recently as winners of foreign fellowships made possible by a \$18,000 grant from Smith Kline & French Laboratories, Philadelphia pharmaceutical firm, and administered by the Association of American Medical Colleges.

Two of the winners are students at medical schools in North Carolina:

Robert L. Browning of Monroe, a junior at the University of North Carolina School of Medicine, received a grant of \$2,423.54 to permit him and his wife, a hospital pharmacist, to spend 11 weeks at a Baptist Mission Hospital in Nigeria, West Africa.

John W. Reed, a junior at the Bowman Gray school of Medicine of Wake Forest College, received \$1,025.90 to spend 10 weeks at the same Baptist Mission Hospital in Nigeria. Reed's parents live in North, South Carolina.

THE WORLD MEDICAL ASSOCIATION

A special chartered plane leaving Paris on September 9, 1961, and arriving in Rio de Janeiro on September 10 has tentatively been scheduled to provide first class accommodations at economy prices for the doctors and their families who will attend the fifteenth General Assembly of the World Medical Association.

A special program of general sightseeing with experienced bilingual guides will be available from September 11 to 14 to those joining the chartered tour. Following the adjournment of the General Assembly the tour will visit Brasilia on September 21; Sao Paulo September 22, and depart for Paris on September 24, arriving on September 25.

The approximate cost for each participant will be \$966.00. This price will include all air transportation, first class hotel accommodations; the registration fee; general sightseeing with our conductors and guides, and three meals daily while on the visit to Sao Paulo and Brasilia.

To obtain additional information address inquiry to:

The World Medical Association
10 Columbus Circle
New York 19, New York

U. S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

The Public Health Service is now accepting applications for graduate training in public health for the 1961-1962 academic year.

Congress established the public health training program in 1956 in recognition of the urgent need to increase the numbers of personnel trained to conduct effective programs in public health agencies. In 1959 the Congress extended the program to operate through June 30, 1964.

The awards provide stipends for living expenses of the trainees in addition to tuition and fees. Information and application forms may be obtained from the Division of Community Health Practice, Public Health Service, Washington 25, D. C.

* * *

Dr. Margaret H. Sloan, National Blood Program executive and staff director of a recent medical research study for the Senate Appro-

priations Committee, has been appointed special assistant to the director of the National Cancer Institute for program development, particularly in the international field.

* * *

The usefulness of tranquilizing drugs in preventing rehospitalization of chronic schizophrenic patients has been demonstrated by research recently reported to the National Institute of Mental Health's Psychopharmacology Service Center, according to Dr. Robert H. Felix, director of the institute.

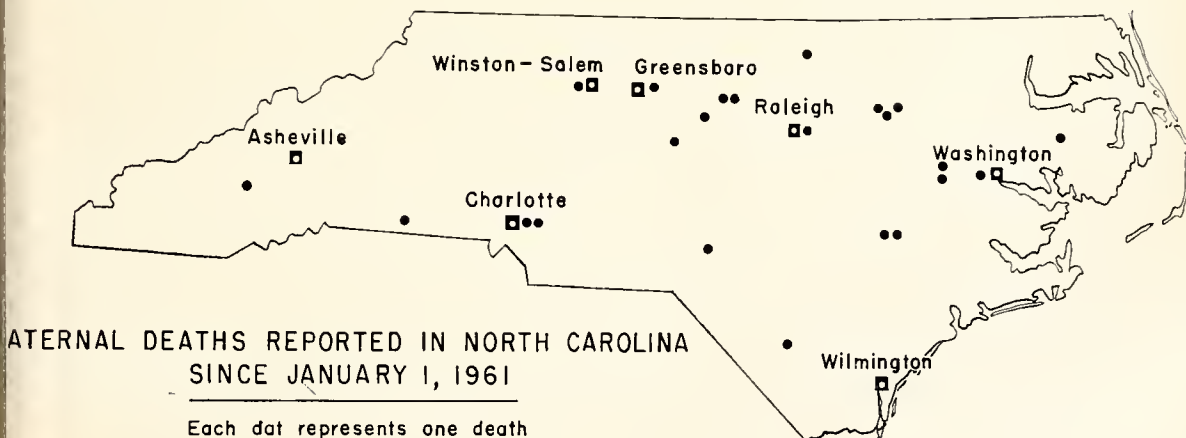
Follow-up studies of released mental patients have shown that under suitable treatment with the drugs, it is possible for many patients who suffer relapse and would otherwise be hospitalized to live at home and in some cases to hold regular employment.

Findings from this study are currently being used in an expanded study to compare the long-term effectiveness of drug treatment outside the hospital, with the results of rehospitalization.

All of these studies have received support from the National Institute of Mental Health through its Research Grants Program.

Patients hospitalized with schizophrenia, the nation's number one mental disorder, stay in mental hospitals almost one and a half times longer than other mentally ill persons, according to the March issue of **Patterns of Disease**, a monthly Parke, Davis & Company publication for physicians. Average hospital residence of a schizophrenic is 10.8 years, compared with 7.5 for patients with other mental disorders.

However, many schizophrenic persons with symptoms not severe enough to warrant hospitalization are treated by physicians other than psychiatrists. Today, 8 of 10 of these patients need not be institutionalized, according to **Patterns**.



Book Review

The Gentle Legions. By Richard Carter. 335 pages. Price \$1.50. New York: Doubleday & Company, Inc., 1961.

In this book Mr. Carter makes it evident that he has the same prejudice against the medical profession that was certainly not disguised in his earlier book, "The Doctor Business." He makes a good case for the non-medical members of the fund-raising organizations, especially the big five—The Red Cross, the American Cancer Society, the American Heart Association, the American Tuberculosis Association, and the National Foundation. He pays a well deserved tribute to the volunteer workers in these groups. He skims over rather lightly the overlapping of interests in the various foundations and the multiplication of organizations for comparatively insignificant diseases.

The final chapter is devoted to the rivalry between the United Fund and the independent groups. This is undoubtedly a most controversial issue—but it is evident that his sympathy is altogether with the independents.

If allowance is made for the author's prejudice against doctors, especially against the American Medical Association, the book can be recommended as a mine of information about the voluntary

fund-raising organizations, especially the big five. Of these it is apparent that the National Foundation is the favorite.

pHisoHex Plays Important Part In Ending "Staph" Epidemic

Continuous education of nursery personnel, plus routine washing with the sudsing detergent pHisoHex, as well as other control measures, helped end an epidemic of staphylococcal infections at Walter Reed General Hospital, a group of medical investigators states in the *U. S. Armed Forces Medical Journal* (11:1415, 1960).

Probably the most important factor in preventing infection, in their opinion, was the "continuous program of educating nursery personnel on the potential hazards of nursery-acquired infection." In January 1959, the incidence of staphylococcal infection in infants born at Walter Reed General Hospital had reached 19 per cent, according to Captain Sherman S. Robinson, Captain Alexander F. Goley, Colonel Ogden C. Bruton and Colonel Hinton J. Baker.

pHisoHex and Zephiran are manufactured by Winthrop Laboratories.

Patterns reports that "while there may be agreement that schizophrenia 'runs in families,' opinions vary as to whether the familial factor is essentially genetic or environmental."

10 big reasons why you will prefer



The Month in Washington

The medical profession, the U. S. Public Health Service and the National Foundation are working together in an all-out drive to get as many persons as possible to take Salk vaccine shots before the summer polio season starts.

The Sabin live polio vaccine will not be available in quantity this year.

The Salk vaccine campaign drive is directed particularly at children and younger adults in the lower economic groups.

Dr. Julian P. Price, Florence, South Carolina, chairman of the American Medical Association's Board of Trustees, pointed out that many children and younger adults in the lower income groups have not been inoculated against polio.

"As long as 'islands of unvaccinated persons' exist even within well-vaccinated communities, polio epidemics remain a serious

From Washington Office of the American Medical Association.

threat," Dr. Price said.

"Contrary to recent reports (in Scripps-Howard Newspapers)," he added, "the A.M.A. is strongly behind every effort to encourage the public to take advantage of the Salk vaccine without delay."

The Committee recommended that the first available supplies of the Sabin live oral vaccine be utilized in the following priority order:

1. Epidemic control, investigations and community studies.
2. Immunization of infants and pre-school school children.
3. Selected area immunization of those segments of the population that are least well immunized.

* * *

Congress now has before it legislation to carry out all of President Kennedy's broad health program, but it is doubtful that the lawmakers will act upon some of it this year.

Kennedy health legislation sent to Congress recently included bills on medical

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1. provides vitamin B12.
2. lipotropic agents to aid fat metabolism.
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education and federal grants for nursing homes and other community facilities.

The Chief Executive also recommended an expanded program to combat water pollution. He requested Congress to authorize federal grants of \$125 million a year for 10 years to help states forming interstate water pollution control agencies. He also recommended increased federal aid to communities building sewage treatment plants.

The President proposed creation of a special unit in the Public Health Service to handle both air and water pollution matters.

In accompanying letters to the presiding officers of the House and the Senate, Kennedy said he regarded his medical education proposals as the keystone of the over-all health program because "we are not presently training enough (physicians) to keep up with our growing population."

The other bill would "make possible a substantial addition to the number of nursing home facilities to care for long-term patients, and . . . help relieve the shortages of home health care programs," Kennedy said.

The medical education measure would authorize federal grants for scholarships for medical and dental students. Each medical and dental school would be eligible for a total of scholarship grants equal to \$1,500 times one-fourth of the enrollment after the program had been in effect for four years. The maximum individual scholarship would be \$2,000 a year. Participating schools also would be eligible for federal grants of \$1,000 per scholarship to help pay a school's operating expenses.

The community health facilities bill would increase the annual authorization for federal grants for construction of non-profit nursing homes from \$10 million to \$20 million and raise the minimum state allotment from \$50,000 to \$100,000 per year. It also would broaden the Public Health Service Surgeon General's authority to conduct research, experiments, and demonstrations on development and utilization of hospital services, facilities, and resources to include other medical facilities.

Federal grants also would be authorized to help finance studies, experiments and

demonstrations by states and other non-federal agencies for development of new or improved methods of providing health services outside hospitals, particularly for chronically ill or aged persons.

The A.M.A. found "much to applaud" in Kennedy's over-all health program, but stood fast in opposing the proposal to provide elderly persons with health care through the social security system. Dr. F.J.L. Blasingame, executive vice president of the A.M.A., said.

"In fact, after studying this section of the President's plan, the A.M.A. more strongly than ever reaffirms its support of the Kerr-Mills law."

Dr. Keefer Named Director of Merck & Co.

Dr. Charles S. Keefer, Director of the Medical Center of Boston University—Massachusetts Memorial Hospitals, and president-elect of the American College of Physicians, was recently elected a director of Merck & Co., Inc., it was announced by Dr. Vannevar Bush, chairman of the Merck Board.

Old Drugs Sometimes Superior To New

"In the vigorous search for new and better drugs, effective and longstanding ones are frequently overlooked or forgotten," according to Drs. Frederick Doran and Dorland F. Smith.

Dose for dose, the analgesic dihydromorphinone hydrochloride (Dilaudid), which was introduced in 1925, was found superior to most of the commonly used analgesics in the hospital. The report, which appears in the February issue of *Clinical Medicine*, states that the older drug produced more effective pain relief in a shorter period of time than other medications. It also caused less frequent and less severe side effects and achieved relief of pain at lower dosage levels.

Dihydromorphinone is synthesized from morphine. The chemical conversion involved ". . . increases the analgesic effect about five times," according to the report, and also results in fewer undesirable side effects.

Classified Advertisement

WANTED: Physician to join group of three physicians. Two general practitioners, one surgeon in town of 7,500 people in Piedmont section, Northwest of Charlotte. Active practice is immediately available and an initial starting income can be guaranteed if desired. The group is affiliated with hospital. All replies confidential. Reply to Box 790, North Carolina Medical Journal, Raleigh, N. C.

Supplement to
**NORTH CAROLINA
MEDICAL JOURNAL**

April, 1961



TRANSACTIONS

ONE HUNDRED SIXTH ANNUAL SESSION

of

The Medical Society of the State
of North Carolina

held at

Raleigh, North Carolina

May 7-11, 1960

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1960
TRANSACTIONS
OF THE
MEDICAL SOCIETY
OF THE STATE OF NORTH CAROLINA

One Hundred Sixth Annual Session

held at

Raleigh, North Carolina

May 7 to 11, 1960

President, John C. Reece, M.D., Morganton

Secretary, John S. Rhodes, M.D., Raleigh

Executive Director, James T. Barnes, Raleigh

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Medical Society of the State of North Carolina

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EDWARD W. SCHOENHEIT, M.D., (Alternate), 46 Haywood St., Asheville

SECTION CHAIRMEN 1959-1960

General Practice of Medicine—JULIUS SADER, M.D., 205 East Main Street, Brevard

Internal Medicine—WALTER SPAETH, M.D., 116 South Road, Elizabeth City

Ophthalmology and Otolaryngology—CHARLES W. TILLET, JR., M.D., 1511 Scott
Avenue, Charlotte

Surgery—JAMES E. DAVIS, M.D., 1200 Broad Street, Durham

Pediatrics—WILLIAM W. FARLEY, M.D., 903 West Peace Street, Raleigh

Obstetrics & Gynecology—H. FLEMING FULLER, M.D., Kinston Clinic, Kinston

Public Health and Education—ISA C. GRANT, M.D., Box 949, Raleigh

Neurology & Psychiatry—MYRON G. SANDIFER, M.D., N. C. Memorial Hospital,
Chapel Hill

Radiology—ISADORE MESCHAN, M.D., Bowman Gray School of Medicine,
Winston-Salem

Pathology—ROGER W. MORRISON, M.D., 65 Sunset Parkway, Asheville

Anesthesia—CHARLES E. WHITCHER, M.D., Route 1, Pfafftown

Orthopedics & Traumatology—CHALMERS R. CARR, M.D., 1822 Brunswick Avenue,
Charlotte

Student AMA Chapters—MR. JOHN FBAGIN, Duke University School of Medicine,
Durham

EARLY HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM ORGANIZATION TO 1804

Date	Place	President	Vice Presidents	Corresponding Secretary	Secretary	Recording Secretary	Treasurer	Censors
Dec. 17, 1799, or April 16, 1800	Raleigh	Richard Fenner	Nathaniel Loomis John Claiborne	Calvin Jones		Wm. B. Hill	Cargill Massenburg	Sterling Wheaton James Webb Jas. John Pasteur Jason Hand
Dec. 1, 1800	Raleigh	Richard Fenner			Sterling Wheaton			
Dec. 1, 1801	Raleigh	John C. Osborne	Thomas Mitchell Richard Fenner	Calvin Jones	Sterling Wheaton		Cargill Massenburg	James Webb John Sibley
1802	Raleigh	John C. Osborne		Calvin Jones				
1803	Raleigh	John C. Osborne		Calvin Jones				
1804	Raleigh	John C. Osborne		Calvin Jones				

HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM 1849 TO 1959

*Missing Data Not to be Found in Record

Date	Place of Meeting	Number in Attendance	President	Vice Presidents*	Secretary	Treasurer*	Members on Roll*	Honorary Members*	Honorary Fellows*
1849	Raleigh	25	F. J. Hill		W. H. McKee		25		
1 1850	Raleigh	21	E. Strudwick	F. J. Haywood, C. E. Johnson, J. E. Williamson, W. G. Thomas	W. H. McKee	W. G. Hill	38	9	
2 1851	Raleigh	23	E. Strudwick	C. E. Johnson	W. H. McKee	W. G. Hill	46	0	
3 1852	Wilmington	38	J. E. Williamson	Thomas N. Cameron, William G. Hill, Johnston B. Jones, N. J. Pittman	E. B. Haywood	J. J. W. Tucker	72	12	
4 1853	Fayetteville	24	J. E. Williamson	William G. Hill, Johnston B. Jones, J. B. G. Myers, N. J. Pittman	W. W. Harris	Daniel Dupree	80	14	
5 1854	Raleigh	37	J. H. Dickson	N. J. Pittman, J. B. G. Myers, J. Graham Tull, A. D. McLean	S. S. Satchwell	Daniel Dupree	84	17	
6 1855	Salisbury	23	J. H. Dickson	J. Graham Tull, Owen Hadley, A. D. McLean, Hugh Kelly	S. S. Satchwell	J. B. Dunn	96	18	
7 1856	Raleigh	35	C. E. Johnson	Marcellus Whitehead, E. R. Gibson, Johnston B. Jones, O. F. Manson	S. S. Satchwell	J. B. Dunn	101	22	
8 1857	Edenton	25	C. E. Johnson	Marcellus Whitehead, O. F. Manson, H. W. Faison, E. T. Gibson	W. G. Thomas	J. B. Dunn	113	16	
9 1858	New Bern	69	W. H. McKee	Edward Warren, C. W. Graham, Caleb Winslow, A. B. Pierce	W. G. Thomas	J. B. Dunn	172	18	
10 1859	Statesville	81	W. H. McKee	James G. Ramsey, P. E. Hines, J. R. Mercer, W. T. Howard	W. G. Thomas	C. W. Graham			
11 1860	Washington	64	N. J. Pittman	P. T. Henry, R. H. Winborne, M. Whitehead, T. S. Leach	W. G. Thomas	C. W. Graham	233	18	
12 1861	Morgauton	23	N. J. Pittman	J. J. Summerell, C. T. Murphy, G. W. Hodges, W. A. B. Norcom	W. G. Thomas	C. W. Graham	244	18	
13 1866	Raleigh	20	J. J. Summerell	E. Burke Haywood, R. H. Winborne, W. L. Barrow, J. W. Jones	W. G. Thomas	C. W. Graham	288	11	
14 1867	Tarboro	41	W. G. Thomas		S. S. Satchwell	C. W. Graham			
15 1868	Warrenton	27	S. S. Satchwell	Hugh Kelly, George A. Foote, Charles J. O'Hagan, J. H. Baker	Thomas F. Wood	J. W. Jones			
16 1869	Salisbury	36	E. B. Haywood	Thomas E. Wilson, A. B. Pierce, C. T. Murphy, M. A. Locke	Thomas F. Wood	J. W. Jones			
17 1870	Wilmington	38	C. J. O'Hagan	E. A. Anderson, F. N. Luckey, W. R. Sharpe, R. L. Payne	Thomas F. Wood	J. W. Jones			
18 1871	Raleigh	35	Hugh Kelley	D. N. Patterson, R. C. Pearson, J. B. Seavy, G. L. Kirby	Thomas F. Wood	J. W. Jones			
19 1872	New Bern	34	W. G. Hill	H. W. Faison, R. I. Hicks, G. H. Macon, W. A. B. Norcom	James McKee	J. W. Jones			
20 1873	Statesville	43	M. Whitehead	W. T. Ennett, William Little, Charles Duffy, P. T. Jermon	James McKee	H. T. Bahnson			
21 1874	Charlotte	56	W. A. B. Norcom	J. B. Jones, R. F. Lewis, C. G. Cox, J. L. Knight	James McKee	H. T. Bahnson			
22 1875	Wilson	60	J. W. Jones	Walker Debnam, J. A. Gibson, William Little, D. N. Patterson	James McKee	H. T. Bahnson	148	5	
23 1876	Fayetteville	33	Peter E. Hines	J. H. Baker, G. G. Smith, T. D. Haigh, J. K. Hall	James McKee	H. T. Bahnson	157	4	
24 1877	Salem	42	George A. Foote	J. K. Hall, B. W. Robinson, A. Holmes, A. A. Hill	James McKee	A. G. Carr	177	4	
25 1878	Goldsboro	79	R. L. Payne	E. M. Rountree, Richard Anderson, S. B. Flowers, L. A. Stith	L. J. Picot	A. G. Carr	194	6	
26 1879	Greensboro	109	Chas. Duffy, Jr.	J. A. Gibson, Willis Alston, James McKee, A. A. Hill	L. J. Picot	A. G. Carr	198	6	
27 1880	Wilmington	105	J. F. Shaffner	J. K. Hall, W. C. McDuffie, W. R. Wilson, R. F. Lewis	L. J. Picot	A. G. Carr	225	6	
28 1881	Asheville	92	R. B. Haywood	J. E. McRee, W. H. Lilly, R. H. Speight, W. J. H. Bellamy	L. J. Picot	A. G. Carr	254	6	
29 1882	Concord	65	Thos. F. Wood	T. J. Moore, D. J. Cain, S. E. Evans, John McDonald	L. J. Picot	A. G. Carr	297	7	
30 1883	Tarboro	112	J. K. Hall	A. W. Knox, J. M. Hadley, E. S. Foster, John Whitehead	L. J. Picot	A. G. Carr	310	7	
31 1884	Raleigh	112	A. B. Pierce	F. W. Potter, G. W. Graham, R. Dillard, G. W. Long	L. J. Picot	A. G. Carr	348	7	
32 1885	Durham	173	W. C. McDuffie	James McKee, T. E. Anderson, W. H. Whitehead, A. G. Carr	W. C. Murphy	R. L. Payne, Jr.	424	6	

SUPPLEMENT — TRANSACTIONS, 1960

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HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM 1849 TO 1959—Continued

*Missing Data Not to be Found in Record

Date	Place of Meeting	Number in Attendance	President	Vice Presidents	Secretary	Treasurer	Members on Roll July 15	Honorary Members	Honorary Fellows*
33 1886	New Bern	113	Joseph Graham	H. T. Bahnson, L. J. Picot, J. L. McMullan, W. W. Faison	J. M. Baker	R. L. Payue, Jr.	438	7	-----
34 1887	Charlotte	112	H. T. Bahnson	G. G. Smith, J. L. Nicholson, C. M. Van Poole, H. B. Ferguson	J. M. Baker	R. L. Payue, Jr.	452	7	-----
35 1888	Fayetteville	133	T. D. Haigh	W. T. Ennett, J. A. Dunn, T. E. Anderson	J. M. Baker	C. M. Van Poole	306	6	-----
36 1889	Elizabeth City	50	W. T. Ennett	W. J. Jones, S. W. Stevenson, G. W. Long	J. M. Baker	C. M. Van Poole	410	6	-----
37 1890	Oxford	160	G. G. Thomas	R. L. Payne, Jr., Richard Dillard, S. D. Booth	J. M. Hays	C. M. Van Poole	414	6	-----
38 1891	Asheville	135	R. H. Lewis	S. W. Battle, J. L. Nicholson, W. H. Lilly	J. M. Hays	C. M. Van Poole	422	6	-----
39 1892	Wilmington	162	W. T. Cheatham	T. S. Burbank, J. W. Long, W. H. H. Cobb, W. D. Hilliard	J. M. Hays	C. M. Van Poole	431	6	-----
40 1893	Raleigh	221	J. W. McNeill	W. C. Galloway, H. H. Harris, J. M. Hadley, Thomas Hill	R. D. Jewett	M. P. Perry	447	5	3
41 1894	Greensboro	166	W. H. H. Cobb	J. A. Hodges, R. W. Tate, Willis Alstoo, M. H. Fletcher	R. D. Jewett	M. P. Perry	454	5	3
42 1895	Goldsboro	---	J. H. Tucker	J. Howell Way, W. H. Harrell, O. McMullan, C. A. Mischeimer	R. D. Jewett	M. P. Perry	436	7	3
43 1896	Winston-Salem	158	R. L. Payne	S. D. Booth, J. P. Munroe, J. A. Burroughs, J. E. Grimsley	R. D. Jewett	M. P. Perry	452	7	3
44 1897	Morehead City	103	P. L. Murphy	J. C. Waltoo, A. A. Kent, M. R. Adams, B. L. Long	R. D. Jewett	M. P. Perry	406	6	3
45 1898	Charlotte	*	Francis Duffy	E. C. Register, A. T. Cotton, J. H. B. Knight, F. H. Russell	R. D. Jewett	M. P. Perry	437	6	21
46 1899	Asheville	152	L. J. Picot	I. W. Faison, J. W. White, H. H. Dodson, W. C. Brownson	Geo. W. Presley	G. T. Sikes	489	6	16
47 1900	Tarboro	115	George W. Long	C. M. Van Poole, James M. Parrott, T. B. Williams, W. D. Hilliard	Geo. W. Presley	G. T. Sikes	482	6	21
48 1901	Durham	186	Julian M. Baker	M. H. Fletcher, C. A. Julian, D. A. Stanton, E. M. Summerell	Geo. W. Presley	G. T. Sikes	515	5	18
49 1902	Wilmington	147	Robert S. Young	A. G. Carr, E. D. Dixon-Carroll, I. M. Taylor, J. M. Parrott	Geo. W. Presley	G. T. Sikes	546	5	20
50 1903	Hot Springs	155	A. W. Knox	E. G. Moore, C. A. Julian, W. W. McKenzie, J. L. Nicholson	J. Howell Way	G. T. Sikes	530	6	19
51 1904	Raleigh	326	H. B. Weaver	John Hey Williams, John C. Rodman, S. F. Fohl	J. Howell Way	G. T. Sikes	1,033	8	17
52 1905	Greensboro	361	David T. Tayloe	C. A. Julian, John T. Burrus, I. W. Faison	J. Howell Way	G. T. Sikes	1,175	8	17
53 1906	Charlotte	406	E. C. Register	L. B. McBrayer, W. H. Cobb, Jr., W. O. Speer	J. Howell Way	G. T. Sikes	1,234	8	16
54 1907	Morehead City	217	Samuel D. Booth	C. M. Strong, J. E. McLaughlin, W. F. Hargrove	David A. Stanton	H. McK. Tucker	888	7	16
55 1908	Winston-Salem	372	J. Howell Way	J. E. Stokes, J. A. Turner, W. H. Dixon	David A. Stanton	H. McK. Tucker	998	7	28
56 1909	Asheville	337	J. F. Highsmith	C. M. Van Poole, D. A. Garrison, D. O. Dees	David A. Stanton	H. McK. Tucker	1,067	7	26
57 1910	Wrightsville Beach	276	J. A. Burroughs, E. J. Wood	E. J. Wood, John Q. Myers, L. D. Wharton	David A. Stanton	H. D. Walker	1,080	8	35
58 1911	Charlotte	412	C. M. Van Poole	J. V. McGougan, W. E. Warren, L. N. Gleason	David A. Stanton	H. D. Walker	880	8	45
59 1912	Heodersonville	296	A. A. Keot	J. P. Moore, W. P. Horton, J. G. Murphy	David A. Stanton	H. D. Walker	950	8	44
60 1913	Morehead City	232	J. P. Munroe	F. R. Harris, E. S. Bunlock, L. B. Morse	John A. Ferrell	H. D. Walker	1,133	8	40
61 1914	Raleigh	431	J. M. Parrott	E. T. Dickinson, J. T. J. Battle, D. E. Sevier	John A. Ferrell	H. D. Walker	1,228	8	47
62 1915	Greensboro	443	L. B. McBrayer	J. J. Phillips, C. W. Mosley, S. M. Crowell	John A. Ferrell	H. D. Walker	1,221	9	68
63 1916	Durham	406	M. H. Fletcher	J. L. Nicholson, L. N. Glenn, W. H. Hardison	Benj. K. Hays	W. M. Jones	1,228	10	79
64 1917	Asheville	280	Charles O'H. Laughinghouse	D. J. Hill, J. L. Spruill, J. H. Shuford	Benj. K. Hays	W. M. Jones	1,271	11	81
65 1918	Pinehurst	291	I. W. Faison	Wm. deB. MacNider, Jos. B. Greene, Beo F. Royal	Benj. K. Hays	W. M. Jones	1,087	11	81
66 1919	Pinehurst	335	Cyrus Thompson	J. W. Halford, T. W. Davis, A. McN. Blair	Sec.-Treas. Benj. K. Hays	Acting Sec.-Treas. L. B. McBrayer	1,306	11	100
67 1920	Charlotte	479	C. V. Reynolds	H. D. Walker, F. Staaley Whitaker, Thos. I. Fox	Benj. K. Hays	L. B. McBrayer	1,497	12	100
68 1921	Pinehurst	404	T. E. Anderson	C. S. Lawrence, W. H. Ward, J. M. Manning	Benj. K. Hays	L. B. McBrayer	1,491	12	93
69 1922	Winston-Salem	507	H. A. Royater	W. T. Parrott, B. C. Nalle, J. R. McCracken		Sec.-Treas. L. B. McBrayer	1,571	12	100
70 1923	Asheville	356	J. W. Loog	F. M. Haes, T. C. Johnson, B. L. Long		L. B. McBrayer	1,592	9	101
71 1924	Raleigh	525	J. V. McGougan	J. L. Spruill, Eugene B. Gleason, D. A. Garrison		L. B. McBrayer	1,604	9	106
72 1925	Pinehurst	550	Albert Anderson	W. L. Dunn, A. E. Bell, K. G. Averitt		L. B. McBrayer	1,657	10	116
73 1926	Wrightsville Beach	445	Wm. deB. MacNider	J. P. Matheson, W. W. Dawson, H. H. Bass		L. B. McBrayer	1,663	10	107
74 1927	Durham	653	John Q. Myers	J. W. Carroll, A. Y. Linville, C. H. Cocke		L. B. McBrayer	1,691	10	121
75 1928	Pinehurst	611	John T. Burrus	G. H. Macon, R. F. Leinbach, W. R. Griffin		L. B. McBrayer	1,738	11	143
76 1929	Greensboro	671	Thnman D. Kitchio	W. L. Dunn, Asheville, D. T. Tayloe, Jr., Washington, W. D. James, Hamlet		L. B. McBrayer	1,866	11	146
77 1930	Pinehurst	701	L. A. Crowell	W. B. Murphy, Wm. E. Warren, N. B. Adams		L. B. McBrayer	1,711	11	155

HISTORY OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA FROM 1849 TO 1959—Continued

Date	Place of Meeting	Number in Attendance	President	President-Elect	Vice Presidents	Sec.-Treas.	Members on Roll July 15	Honorary Members	Life Members
78 1931	Durham.....	714	J. G. Murphy.....	M. L. Stevens.....	C. A. Julian, Greensboro J. W. Davis, Statesville.....				
79 1932	Winston-Salem.....	740	M. L. Stevens.....	Jno. B. Wright.....	C. W. Banner, Greensboro W. W. Sawyer, Elizabeth City.....	L. B. McBrayer.....	1,600	10	184
80 1933	Raleigh.....	714	Jno. B. Wright.....	I. H. Manning.....	J. R. McCracken, Waynesville.....	L. B. McBrayer.....	1,559	10	186
81 1934	Pinehurst.....	728	I. H. Manning.....	P. P. McCain.....		L. B. McBrayer.....	1,363	10	181
82 1935	Pinehurst.....	706	P. P. McCain.....	Paul H. Ringer.....	W. G. Suiter, Weldon R. I. Felts, Durham.....	L. B. McBrayer.....	1,563	10	210
83 1936	Asheville.....	583	Paul H. Ringer.....	C. F. Strosnider.....	H. D. Walker, Elizabeth City J. F. McKay, Buie's Creek William Allan, Charlotte.....	L. B. McBrayer.....	1,619	10	215
84 1937	Winston-Salem.....	767	C. F. Strosnider.....	Wingate M. Johnson.....	J. K. Pepper, Winston-Salem E. S. Bulluck, Wilmington.....	L. B. McBrayer.....	1,462	10	235
85 1938	Pinehurst.....	802	Wingate M. Johnson.....	J. Buren Sidbury.....	C. A. Woodard, Wilson Jno. F. Brownberger, Fletcher.....	L. B. McBrayer.....	1,503	7	253
86 1939	Cruise to Bermuda.....	319	J. Buren Sidbury.....	William Allan.....	R. B. McKnight, Charlotte J. F. Abel, Waynesville.....	T. W. M. Long.....	1,715	7	284
87 1940	Pinehurst.....	835	William Allan.....	Hubert B. Haywood.....	C. B. Williams, Elizabeth City M. D. Hill, Raleigh.....	T. W. M. Long.....	1,605	8	313
88 1941	Pinehurst.....	756	Hubert B. Haywood.....	F. Webb Griffith.....	F. Webb Griffith, Asheville Frank C. Smith, Charlotte.....	T. W. M. Long.....	1,661	7	311
89 1942	Charlotte.....	710	F. Webb Griffith.....	Donnel B. Cobb.....	D. W. Holt, Greensboro T. C. Kerns, Durham.....	T. W. M. Long (1) I. H. Manning.....	1,700	7	309
90 1943	Raleigh.....	736	Donnell B. Cobb.....	James W. Vernon.....	Thos. DeL. Sparrow, Charlotte T. L. Carter, Gatesville.....	Roscoe D. McMillan.....	1,837	8	360
91 1944	Pinehurst.....	760	James W. Vernon.....	Paul F. Whitaker.....	George S. Coleman, Raleigh Julian Moore, Asheville.....	Roscoe D. McMillan.....	1,919	8	361
1945	No meeting because of O.D.T. restrictions		Paul F. Whitaker.....	Oren Moore.....	Fred C. Hubbard, North Wilkesboro George L. Carrington, Burlington.....	Roscoe D. McMillan.....	1,982	8	363
92 1946	Pinehurst.....	889	Oren Moore.....		Wm. H. Smith, Goldsboro Zack D. Owens, Elizabeth City.....	Roscoe D. McMillan.....	1,811	7	383
93 1947	Virginia Beach, Va.....	444	Wm. M. Coppridge.....	Frank A. Sharpe.....	Wm. H. Smith, Goldsboro Zack D. Owens, Elizabeth City.....	Roscoe D. McMillan.....	1,939	6	397
94 1948	Pinehurst.....	920	Frank A. Sharpe (2).....	James F. Robertson.....	G. E. Bell, Wilson J. B. Bullitt, Chapel Hill.....	Roscoe D. McMillan.....	2,191	7	404
95 1949	Pinehurst.....	998	James F. Robertson.....	G. Westbrook Murphy.....	V. K. Hart, Charlotte J. G. Raby, Tarboro.....	Roscoe D. McMillan.....	2,298	8	407
96 1950	Pinehurst.....	947	G. Westbrook Murphy.....	Roscoe D. McMillan.....	Joseph J. Combs, Raleigh Joseph A. Elliott, Charlotte.....	Roscoe D. McMillan.....	2,318	5	405
97 1951	Pinehurst.....	938	Roscoe D. McMillan.....	Frederic C. Hubbard.....	Ben F. Royal Joseph A. Elliott.....	Millard D. Hill.....	2,283	5	465
98 1952	Pinehurst.....	969	Frederic C. Hubbard.....	J. Street Brewer.....	Henderson Irwin Forest M. Houser.....	Millard D. Hill.....	2,341	5	469
99 1953	Pinehurst.....	1016	J. Street Brewer.....	Joseph A. Elliott.....	Arthur Daughtridge George W. Paschal.....	Millard D. Hill.....	2,326	5	476
100 1954	Pinehurst.....	1077	Joseph A. Elliott.....	Zack D. Owens.....	John R. Bender John F. Foster.....	Millard D. Hill.....	2,673	5	486
101 1955	Pinehurst.....	991	Zack D. Owens.....	J. P. Rousseau.....	Julian A. Moore George W. Paschal, Jr.....	Millard D. Hill.....	2,801	6	486
102 1956	Pinehurst.....	1022	James P. Rousseau.....	Donald B. Koonce.....	Elias S. Faison E. W. Schoenheit.....	Millard D. Hill.....	2,896	6	507
103 1957	Asheville.....	867	Donald B. Koonce.....	Edward W. Schoenheit.....	Milton S. Clark John S. Rhodes.....	Millard D. Hill.....	3,058	7	561
104 1958	Asheville.....	781	Edw. W. Schoenheit.....	Lenox D. Baker.....	O. Norris Smith George W. Holmes.....	Millard D. Hill.....	3,127	8	522
105 1959	Asheville.....	651	Lenox D. Baker.....	John C. Reece.....	Amos N. Johnson Amos N. Johnson.....	Millard D. Hill.....	3,171	9	542
106 1960	Raleigh.....	848	John C. Reece.....	Amos N. Johnson.....	Kenneth B. Geddie Charles M. Norfleet, Jr. W. Walton Kitchen.....	John S. Rhodes.....	3,211	10	251
						John S. Rhodes.....	3,247	12	472

†Died during his term of office; succeeded by E. J. Wood, first vice president.

(2) Died during term of office; succeeded by James F. Robertson, president-elect.

‡Died during term of office.

(1) Died during term of office; succeeded by I. H. Manning

STATUS OF MEMBERSHIP BY COUNTIES—Continued

COUNTY	1932	1933	1934	1935	1936	1937	1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960
Mitchell-Avery 13	5	8																											
Mitchell-Watauga 14																													
Mitchell-Yancey	7	7																											
Montgomery 15	21	18	22	21	19	22	21	20	19	17	22	21	21	20	22	23	26	26	28	28	26	29	33	35	34	32	31	32	32
Moore																													
Nash 16	35	25	35	39	34	36	32	39	37	38	43	44	45	40	49	55	62	53	56	56	63	65	68	69	73	76	72	76	80
New Hanover	3	4	8	4	4	3	3	1	3	7	4	4	3	3	2	3	4	4	4	4	3	3	5	3	3	3	4	4	1
Northampton	6	6	6	5	2	5	4	4	3	5	5	8	8	8	8	10	10	12	11	11	11	10	10	10	12	13	12	12	11
Onslow																													
Orange 17	4	4	4	4	4	4	4	4	4	3	3	3	4	5	4	4	4	4	4	4	4	4	5	5	5	4	4	1	1
Pamlico																													
Pasquotank-Camden																													
Currituck-Dare	12	14	14	12	11	9		9	1	10	14	13	12	11	16	17	21	16	20	20	26	27	25	27	28	29	28	26	26
Pasquotank-Chatham																													
Dare 8	11	1	1	1																									
Pender																													
Perquimans 18	6	7	7	8	7	7	8	8	9	8	8	8	8	8	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
Pitt	20	14	22	26	24	26	30	29	28	25	29	30	31	32	30	31	32	32	31	31	29	34	40	43	46	40	40	40	40
Polk	7	7	6	6	4	5	5	5	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6
Polk	14	10	11	13	10	9	11	11	13	12	12	13	14	15	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Richmond	15	16	15	16	15	17	16	15	16	16	15	17	17	18	18	19	20	20	20	20	20	20	20	20	20	20	20	20	20
Robeson	22	23	25	27	28	29	34	33	35	35	35	36	38	38	38	40	47	47	45	45	42	42	44	48	45	43	46	46	46
Rockingham	21	22	23	21	18	20	18	22	22	26	24	29	29	29	29	29	29	31	30	30	30	30	32	37	36	37	37	37	37
Rowan-Davie	33	21	34	30	27	28	26	24	27	34	33	33	42	41	41	41	49	47	46	44	42	45	48	58	60	60	60	60	60
Rutherford	21	19	20	21	23	22	23	24	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22	22
Sampson	14	14	14	14	14	16	16	16	18	18	18	15	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16	16
Scotland	11	11	11	11	10	11	10	10	10	10	10	9	10	10	10	10	12	10	13	13	13	14	14	14	14	14	14	14	14
Stanly 15	13	12	16	17	18	19	18	20	16	17	20	20	17	16	18	18	21	26	22	22	24	25	26	29	29	29	27	27	28
Stokes	6	1	1	1																									
Surry 19	17	12																											
Surry-Yadkin																													
Swain 10																													
Transylvania	1	3	2	2	2	2	2	3	1	7	8	10	9	7	7	6	6	4	7	8	7	10	10	11	9	11	11	12	13
Tyrrell 29																													
Union	9	10	10	11	10	8	11	13	13	14	15	14	14	3	13	14	14	14	15	15	16	17	15	15	16	17	16	15	15
Vance																													
Wake	7	8	9	9	8	8	6	10	10	10	12	10	10	8	11	11	12	12	11	11	12	13	14	15	17	16	14	15	15
Warren	86	87	89	88	89	85	100	95	94	93	87	98	96	96	92	110	108	114	120	126	114	146	152	147	155	156	158	150	165
Washington-Tyrrell 11	3																												
Washington 21																													
Watauga-Ashe 22	3	5	5	6	5	5	6	6	4	5	7	8	5	2	7	38	38	37	37	37	38	41	37	39	42	43	44	47	50
Wayne	32	22	27	29	27	29	30	31	34	33	35	38	38	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37	37
Wilkes 2	10																												
Wilkes-Allegany																													
Wilson	9	13	10	14	13	14	14	15	13	16	17	17	17	14	16	17	17	18	18	19	17	17	18	21	20	21	22	23	17
Yadkin 19	22	21	25	29	31	25	25	25	24	27	27	31	29	27	30	33	33	33	28	28	30	34	34	37	36	38	39	38	40
Yancey	4	1																											
Totals	1,559	1,363	1,563	1,619	1,462	1,503	1,715	1,605	1,661	1,694	1,837	1,919	1,982	1,811	1,639	2,191	2,298	2,318	2,278	2,343	2,326	2,673	2,801	2,806	3,058	3,127	3,171	3,211	3,247

(1) See Iredell-Alexander. (2) See Wilkes-Allegany. (3) See Watauga-Ashe and Ashe-Watauga. (4) See Mitchell-Avery. (5) See Pasquotank-Camden-Dare and Pasquotank-Camden-Currituck-Dare. (6) See Alamance-Caswell. (7) See Macon-Clay. (8) See Pasquotank-Camden-Currituck-Dare. (9) See Rowan-Davie. (10) See Jackson-Swain. (11) See Martin-Washington-Tyrrell. (12) See Mitchell-Avery. Mitchell-Watauga, and Mitchell-Yancey. (13) See Avery and Mitchell. (14) See Mitchell, Watauga-Ashe, and Ashe-Watauga. (15) See Stanly-Montgomery, Montgomery, and Stanly. (16) See Edgecombe-Nash. (17) See Durham-Orange. (18) See Chowan-Perquimans. (19) See Surry-Yadkin. (20) See Washington-Tyrrell and Martin-Washington-Tyrrell. (21) See Mitchell-Watauga, Watauga-Ashe, and Ashe-Watauga. (22) See Ashe-Watauga.

ROSTER OF MEMBERS OF NORTH CAROLINA STATE BOARD OF HEALTH FROM ORGANIZATION IN 1877 TO 1961

<i>Name</i>	<i>Address</i>	<i>Appointed by</i>	<i>Term</i>
S. S. Satchwell, M.D., President	Rocky Point	State Society	1877 to 1878
Thomas F. Wood, M.D., Secretary	Wilmington	State Society	1877 to 1878
Joseph Graham, M.D.	Charlotte	State Society	1877 to 1878
Charles Duffy, Jr., M.D.	New Bern	State Society	1877 to 1878
Peter E. Hines, M.D.	Raleigh	State Society	1877 to 1878
George A. Foote, M.D.	Warrenton	State Society	1877 to 1878
S. S. Satchwell, M.D., President	Rocky Point	State Society	1878 to 1884
Thomas F. Wood, M.D., Secretary	Wilmington	State Society	1878 to 1884
Charles J. O'Hagan, M.D., President	Greenville	State Society	1878 to 1882
George A. Foote, M.D.	Warrenton	State Society	1878 to 1882
Marcellus Whitehead, M.D.	Salisbury	State Society	1878 to 1880
R. L. Payne, M.D.	Lexington	State Society	1878 to 1880
H. G. Woodfin, M.D.	Franklin	Gov. Z. B. Vance	1878 to 1880
A. R. Ledoux, Chemist	Chapel Hill	Gov. Z. B. Vance	1878 to 1880
William Cain, Civil Engineer	Charlotte	Gov. Z. B. Vance	1878 to 1880
R. L. Payne, M.D.	Lexington	State Society	1881 to 1887
M. Whitehead, M.D., President	Salisbury	State Society	1881 to 1884
S. H. Lyle, M.D.	Franklin	Gov. T. J. Jarvis	1881 to 1883
William Cain, Civil Engineer	Charlotte	Gov. T. J. Jarvis	1881 to 1883
W. G. Simmons, Chemist	Wake Forest	Gov. T. J. Jarvis	1881 to 1883
J. W. Jones, M.D., President	Wake Forest	State Society	1883 to 1889
John McDonald, M.D.	Washington	State Society	1883 to 1889
S. H. Lyle, M.D.	Franklin	Gov. T. J. Jarvis	1883 to 1885
W. G. Simmons, Chemist	Wake Forest	Gov. T. J. Jarvis	1883 to 1885
Arthur Winslow, Civil Engineer	Raleigh	Gov. T. J. Jarvis	1884 to 1886
R. H. Lewis, M.D.	Raleigh	State Board of Health	1884 to 1886
Thomas F. Wood, M.D., Secretary	Wilmington	State Society	1885 to 1887
William D. Hilliard, M.D.	Asheville	State Society	1885 to 1891
Arthur Winslow, Civil Engineer	Raleigh	Gov. A. M. Scales	1885 to 1891
W. G. Simmons, Chemist	Wake Forest	Gov. A. M. Scales	1885 to 1887
J. H. Tucker, M.D.	Henderson	Gov. A. M. Scales	1885 to 1887
R. H. Lewis, M.D., Secretary	Raleigh	State Society	1887 to 1888
H. T. Bahnson, M.D., President	Winston	State Society	1887 to 1888
Arthur Winslow, Civil Engineer	Raleigh	Gov. A. M. Scales	1887 to 1889
W. G. Simmons, Chemist	Wake Forest	Gov. A. M. Scales	1887 to 1889
J. H. Tucker, M.D.	Henderson	Gov. A. M. Scales	1888 to 1891
J. L. Ludlow, Civil Engineer	Winston	Gov. A. M. Scales	1888 to 1891
J. H. Tucker, M.D.	Henderson	Gov. D. G. Fowle	1888 to 1891
F. P. Venable, Ph.D. Chemist	Chapel Hill	Gov. D. G. Fowle	1889 to 1893
J. L. Ludlow, Civil Engineer	Winston	Gov. D. G. Fowle	1889 to 1892
J. A. Hodges, M.D.	Fayetteville	State Society	1889 to 1893
J. M. Baker, M.D.	Tarboro	State Society	1891 to 1893
J. H. Tucker, M.D.	Henderson	Gov. T. M. Holt	1891 to 1893
F. P. Venable, Ph.D., Chemist	Chapel Hill	Gov. T. M. Holt	1891 to 1892
J. L. Ludlow, Civil Engineer	Winston	Gov. T. M. Holt	1892 to 1897
Thomas F. Wood, M.D., Secretary†	Wilmington	State Society	1891 to 1895
George G. Thomas, M.D., President	Wilmington	State Board of Health	1892 to 1895
S. Westray Battle, M.D.	Asheville	State Society	1893 to 1895
W. H. Harrell, M.D.	Williamston	State Society	1893 to 1895
John Whitehead, M.D.	Salisbury	State Board of Health	1893 to 1895
W. H. G. Lucas	White Hall	Gov. Elias Carr	1893 to 1895
F. P. Venable, Ph.D., Chemist	Chapel Hill	Gov. Elias Carr	1893 to 1895
John C. Chase, Civil Engineer	Wilmington	Gov. Elias Carr	1894 to 1897
R. H. Lewis, M.D., Secretary	Raleigh	Gov. Elias Carr	1895 to 1897
W. P. Beall, M.D.	Greensboro	Gov. Elias Carr	1895 to 1897
W. J. Lumsden, M.D.	Elizabeth City	Gov. Elias Carr	1895 to 1897
John Whitehead, M.D.	Salisbury	State Society	1895 to 1897
W. H. Harrell, M.D.	Williamston	State Society	1895 to 1897
W. P. Beall, M.D.	Greensboro	Gov. Elias Carr	1895 to 1897
R. H. Lewis, M.D., Secretary	Raleigh	Gov. Elias Carr	1897 to 1899
F. P. Venable, Ph.D., Chemist	Chapel Hill	Gov. Elias Carr	1897 to 1899
John C. Chase, Civil Engineer	Wilmington	Gov. Elias Carr	1897 to 1899
Charles J. O'Hagan, M.D.	Greenville	Gov. D. L. Russell	1897 to 1899
John D. Spicer, M.D.	Goldsboro	Gov. D. L. Russell	1897 to 1899
J. L. Nicholson, M.D.	Richlands	Gov. D. L. Russell	1899 to 1901
R. H. Lewis, M.D., Secretary	Raleigh	Gov. D. L. Russell	1899 to 1901
A. W. Shaffer, Civil Engineer	Raleigh	Gov. D. L. Russell	1899 to 1901
Charles J. O'Hagan, M.D.	Greenville	Gov. D. L. Russell	1899 to 1901
J. L. Nicholson, M.D.	Richlands	Gov. D. L. Russell	1899 to 1901
Albert Anderson, M.D.	Wilson	Gov. D. L. Russell	1899 to 1901
George G. Thomas, M.D., President	Wilmington	State Society	1899 to 1901

† Died in 1892, leaving a five-year unexpired term, which was filled by the Board

<i>Name</i>	<i>Address</i>	<i>Appointed by</i>	<i>Term</i>
S. Westray Battle, M.D.	Asheville	State Society	1899 to 1901
H. W. Lewis, M.D.	Jackson	State Society	1899 to 1901
H. H. Dodson, M.D.	Milton	State Society	1901 to 1907
R. H. Lewis, M.D., Secretary	Raleigh	Gov. C. B. Aycock	1901 to 1907
W. P. Ivey, M.D.	Lenoir	Gov. C. B. Aycock	1901 to 1907
George G. Thomas, M.D., President	Wilmington	Gov. C. B. Aycock	1901 to 1905
Francis Duffy, M.D.	New Bern	Gov. C. B. Aycock	1901 to 1905
J. L. Ludlow, Civil Engineer	Winston	Gov. C. B. Aycock	1901 to 1905
S. Westray Battle, M.D.	Asheville	State Society	1901 to 1907
H. W. Lewis, M.D.	Jackson	State Society	1901 to 1907
W. H. Whitehead, M.D.	Rocky Mount	State Society	1901 to 1905
J. L. Nicholson, M.D.	Richlands	State Society	1901 to 1905
J. L. Ludlow, Civil Engineer	Winston	Gov. C. B. Aycock	1903 to 1909
J. Howell Way, M.D.	Waynesville	Gov. R. B. Glenn	1905 to 1911
W. O. Spencer, M.D.	Winston	Gov. R. B. Glenn	1905 to 1911
George G. Thomas, M.D., President	Wilmington	State Society	1905 to 1911
Thomas E. Anderson, M.D.	Statesville	State Society	1907 to 1913
R. H. Lewis, M.D.	Raleigh	Gov. R. B. Glenn	1907 to 1913
E. C. Register, M.D.	Charlotte	Gov. R. B. Glenn	1907 to 1909
David T. Tayloe, M.D.	Washington	State Society	1907 to 1913
James A. Burroughs, M.D. ¹	Asheville	State Society	1909 to 1913
J. E. Ashcraft, M.D.	Monroe	State Board of Health	1909 to 1913
J. L. Ludlow, Civil Engineer	Winston-Salem	Gov. W. W. Kitchin	1911 to 1917
J. Howell Way, M.D., President	Waynesville	Gov. W. W. Kitchin	1911 to 1917
W. O. Spencer, M.D.	Winston-Salem	Gov. W. W. Kitchin	1911 to 1917
Thomas E. Anderson, M.D.	Statesville	State Society	1911 to 1917
Charles O'H. Laughinghouse, M.D.	Greenville	State Society	1913 to 1919
R. H. Lewis, M.D.	Raleigh	Gov. Locke Craig	1913 to 1919
Edw. J. Wood, M.D.	Wilmington	Gov. Locke Craig	1913 to 1915
A. A. Kent, M.D. ²	Lenoir	State Society	1913 to 1919
Cyrus Thompson, M.D.	Jacksonville	State Society	1913 to 1919
Fletcher R. Harris, M.D.	Henderson	State Board of Health	1915 to 1921
J. L. Ludlow, Civil Engineer	Winston-Salem	Gov. Locke Craig	1917 to 1923
J. Howell Way, M.D., President	Waynesville	Gov. T. W. Bickett	1917 to 1923
E. C. Register, M.D. ¹	Charlotte	Gov. T. W. Bickett	1917 to 1923
Thomas E. Anderson, M.D.	Statesville	State Society	1917 to 1923
Charles O'H. Laughinghouse, M.D.	Greenville	State Society	1919 to 1923
Fletcher R. Harris, M.D. ³	Henderson	State Society	1919 to 1923
A. J. Crowell, M.D.	Charlotte	Gov. T. W. Bickett	1921 to 1923
Chas. E. Waddell, C. E. ¹	Asheville	Gov. C. Morrison	1919 to 1925
Cyrus Thompson, M.D.	Jacksonville	State Society	1919 to 1925
R. H. Lewis, M.D.	Raleigh	Gov. T. W. Bickett	1923 to 1925
E. J. Tucker, D.D.S.	Roxboro	Gov. T. W. Bickett	1923 to 1929
J. Howell Way, M.D., President	Waynesville	Gov. C. Morrison	1923 to 1929
A. J. Crowell, M.D.	Charlotte	Gov. C. Morrison	1923 to 1927
James P. Stowe, Ph.G.	Charlotte	Gov. C. Morrison	1923 to 1925
D. A. Stanton, M.D.	High Point	State Board of Health	1923 to 1929
Thomas E. Anderson, M.D.	Statesville	State Society	1923 to 1926
Charles O'H. Laughinghouse, M.D. ⁵	Greenville	State Society	1925 to 1931
Cyrus Thompson, M.D. ¹	Jacksonville	State Society	1925 to 1931
D. A. Stanton, M.D.	High Point	State Society	1925 to 1931
R. H. Lewis, M.D. ¹	Raleigh	Gov. A. W. McLean	1926 to 1931
Jno. B. Wright, M.D. ⁶	Raleigh	Gov. A. W. McLean	1925 to 1931
E. J. Tucker, D.D.S. ⁶	Roxboro	Gov. A. W. McLean	1926 to 1927
W. S. Rankin, M.D. ¹	Charlotte	State Board of Health	1927 to 1929
L. E. McDaniel, M.D.	Jackson	State Board of Health	1927 to 1929
Chas. C. Orr, M.D.	Asheville	Gov. A. W. McLean	1929 to 1935
Thomas E. Anderson, M.D. ⁶	Statesville	State Society	1929 to 1935
L. E. McDaniel, M.D. ⁶	Jackson	State Society	1927 to 1933
James P. Stowe, Ph.G. ⁶	Charlotte	Gov. A. W. McLean	1929 to 1935
A. J. Crowell, M.D. ⁶	Charlotte	Gov. O. Max Gardner	1930 to 1931
J. M. Parrott, M.D. ⁶	Kinston	State Board of Health	1929 to 1935
Chas. C. Orr, M.D. ⁶	Asheville	Gov. O. Max Gardner	1931 to 1935
J. M. Parrott, M.D. ⁵	Kinston	State Society	1931 to 1935
C. V. Reynolds, M.D.	Asheville	State Society	1931 to 1933
L. B. Evans, M.D.	Windsor	State Society	1931 to 1933
S. D. Craig, M.D.	Winston-Salem	State Society	1931 to 1933
John T. Burrus, M.D.	High Point	Gov. O. Max Gardner	1931 to 1933
J. N. Johnson, D.D.S.	Goldsboro	Gov. O. Max Gardner	1931 to 1933
J. A. Goode, Ph.G.	Asheville	Gov. O. Max Gardner	1931 to 1933
H. L. Large, M.D.	Rocky Mount	Gov. O. Max Gardner	1931 to 1935
H. G. Baity, C.E.	Chapel Hill	Gov. O. Max Gardner	1931 to 1935

¹ Died leaving unexpired term.² Resigned to become member of General Assembly.³ Resigned to become Health Officer Vance County.⁴ Resigned.⁵ Resigned to become Secretary of State Board of Health⁶ Term terminated on account of the reorganization of the State Board of Health by General Assembly.

<i>Name</i>	<i>Address</i>	<i>Appointed by</i>	<i>Term</i>
Grady G. Dixon, M.D. ⁷	Ayden	Ex. Com. State Society	1931 to 1932
Grady G. Dixon, M.D. ⁷	Ayden	State Society	1932 to 1935
S. D. Craig, M.D.	Winston-Salem	State Society	1933 to 1937
W. T. Rainey, M.D.	Fayetteville	State Society	1933 to 1937
J. N. Johnson, D.D.S.	Goldsboro	Gov. J. C. B. Ehringhaus	1933 to 1937
Hubert B. Haywood, M.D.	Raleigh	Gov. J. C. B. Ehringhaus	1933 to 1937
James P. Stowe, Ph.G.	Charlotte	Gov. J. C. B. Ehringhaus	1933 to 1937
Grady G. Dixon, M.D.	Ayden	State Society	1935 to 1939
J. LaBruce Ward, M.D.	Asheville	State Society	1935 to 1939
H. Lee Large, M.D.	Rocky Mount	Gov. J. C. B. Ehringhaus	1935 to 1939
H. G. Baity, C.E.	Chapel Hill	Gov. J. C. B. Ehringhaus	1935 to 1939
J. N. Johnson, D.D.S.	Goldsboro	Gov. Clyde R. Hoey	1937 to 1941
Hubert B. Haywood, M.D.	Raleigh	Gov. Clyde R. Hoey	1937 to 1941
James P. Stowe, Ph.G.	Charlotte	Gov. Clyde R. Hoey	1937 to 1941
S. D. Craig, M.D.	Winston-Salem	State Society	1937 to 1941
W. T. Rainey, M.D.	Fayetteville	State Society	1937 to 1941
Grady G. Dixon, M.D.	Ayden	State Society	1939 to 1943
J. LaBruce Ward, M.D.	Asheville	State Society	1939 to 1943
H. Lee Large, M.D.	Rocky Mount	Gov. Clyde R. Hoey	1939 to 1943
H. G. Baity, Sc.D.	Chapel Hill	Gov. Clyde R. Hoey	1939 to 1943
C. C. Fordham, Jr., Ph.G. ⁸	Greensboro	Gov. Clyde R. Hoey	1940 to 1943
S. D. Craig, M.D.	Winston-Salem	State Society	1941 to 1945
W. T. Rainey, M.D.	Fayetteville	State Society	1941 to 1945
Hubert B. Haywood, M.D.	Raleigh	Gov. J. Melville Broughton	1941 to 1945
J. N. Johnson, D.D.S.	Goldsboro	Gov. J. Melville Broughton	1941 to 1945
James O. Nolan, M.D.	Kannapolis	Gov. J. Melville Broughton	1941 to 1945
Grady G. Dixon, M.D.	Ayden	State Society	1943 to 1947
J. LaBruce Ward, M.D.	Asheville	State Society	1943 to 1947
H. Lee Large, M.D.	Rocky Mount	Gov. J. Melville Broughton	1943 to 1947
Larry I. Moore, Jr.	Wilson	Gov. J. Melville Broughton	1943 to 1947
S. D. Craig, M.D., Pres.	Winston-Salem	State Society	1945 to 1949
W. T. Rainey, M.D.	Fayetteville	State Society	1945 to 1949
Hubert B. Haywood, M.D.	Raleigh	Gov. R. Gregg Cherry	1945 to 1949
James O. Nolan, M.D.	Kannapolis	Gov. R. Gregg Cherry	1945 to 1949
Paul Jones, D.D.S. ⁹	Farmville	Gov. R. Gregg Cherry	1946 to 1949
Jasper C. Jackson, Ph.G. ¹⁰	Lumberton	Gov. R. Gregg Cherry	1945 to 1947
Grady G. Dixon, M.D., Pres.	Ayden	State Society	1947 to 1951
H. Lee Large, M.D.	Rocky Mount	Gov. R. Gregg Cherry	1947 to 1951
J. LaBruce Ward, M.D.	Asheville	State Society	1947 to 1951
Hubert B. Haywood, M.D.	Raleigh	Gov. W. Kerr Scott	1949 to 1953
Mrs. James B. Hunt	Lucama	Gov. W. Kerr Scott	1949 to 1953
A. C. Current, D.D.S.	Gastonia	Gov. W. Kerr Scott	1949 to 1953
John R. Bender, M.D.	Winston-Salem	State Society	1949 to 1953
Benjamin J. Lawrence, M.D.	Raleigh	State Society	1949 to 1953
G. Grady Dixon, M.D.	Ayden	Medical Society	1951 to 1955
George Curtis Crump, M.D.	Asheville	Medical Society	1951 to 1955
John P. Henderson, Jr., M.D. ¹¹	Sneads Ferry	Gov. Wm. B. Umstead	1954 to 1955
H. C. Lutz, Phg.	Hickory	Gov. W. Kerr Scott	1951 to 1955
Hubert B. Haywood, M.D. ¹²	Raleigh	Gov. Wm. Umstead	1953 to 1957
Mrs. J. E. Latta	Hillsboro	Gov. Wm. Umstead	1953 to 1957
A. C. Current, D.D.S.	Gastonia	Gov. Wm. Umstead	1953 to 1957
John R. Bender, M.D.	Winston-Salem	Medical Society	1953 to 1957
Benjamin J. Lawrence, M.D.	Raleigh	Medical Society	1953 to 1957
G. Grady Dixon, M.D. ¹⁵	Ayden	Medical Society	1955 to 1959
George Curtis Crump, M.D. ¹²	Asheville	Medical Society	1955 to 1959
Roger W. Morrison, M.D. ¹⁴	Asheville	Medical Society	1957 to 1957
John P. Henderson, Jr., M.D.	Sneads Ferry	Gov. Luther H. Hodges	1955 to 1959
H. C. Lutz, Phg.	Hickory	Gov. Luther H. Hodges	1955 to 1959
Lenox D. Baker, M.D. ¹³	Durham	Gov. Luther H. Hodges	1956 to 1957
Earl W. Brain, M.D. ¹⁶	Raleigh	Medical Society	1958 to 1959
Mrs. J. E. Latta	Hillsboro	Gov. Luther H. Hodges	1957 to 1961
Roger W. Morrison, M.D.	Asheville	Medical Society	1957 to 1959
John R. Bender, M. D.	Winston-Salem	Medical Society	1957 to 1961
Z. L. Edwards, D.D.S.	Washington	Gov. Luther H. Hodges	1957 to 1961
Chas. R. Bugg, M.D., Pres.	Raleigh	Medical Society	1957 to 1961
Lenox D. Baker, M.D.	Durham	Gov. Luther H. Hodges	1957 to 1961

7 To fill vacancy caused by resignation of Dr. J. M. Parrott.

8 To fill vacancy caused by the death of James P. Stowe, Ph.G.

9 To fill vacancy caused by resignation of J. N. Johnson, D.D.S.

10 To fill vacancy caused by resignation of Larry I. Moore, Jr.

11 To fill vacancy caused by the death of Dr. H. Lee Large.

12 Resigned.

13 To fill vacancy caused by resignation of Dr. Hubert B. Haywood.

14 To fill vacancy caused by resignation of Dr. George Curtis Crump.

15 Died leaving unexpired term.

16 To fill vacancy caused by the death of Dr. G. Grady Dixon.

ROSTER OF MEMBERS OF THE VARIOUS BOARDS OF MEDICAL EXAMINERS OF THE STATE OF NORTH CAROLINA

FIRST BOARD

James H. Dickson, Wilmington	1859-1866
Charles E. Johnson, Raleigh	1859-1866
Caleb Winslow, Hertford	1859-1866
Otis F. Manson, Townsville	1859-1866
William H. McKee, Raleigh	1859-1866
Christopher Happoldt, Morganton	1859-1866
J. Graham Tull, New Bern	1859-1866
Samuel T. Iredell, Secretary	1859-1866

SECOND BOARD

N. J. Pittman, Tarboro	1866-1872
E. Burke Haywood, Raleigh	1866-1872
R. H. Winborne, Edenton	1866-1872
S. S. Satchwell, Rocky Point	1866-1872
J. J. Summerell, Salisbury	1866-1872
R. B. Haywood, Raleigh	1866-1872
M. Whitehead, Salisbury	1866-1872
J. F. Shaffner, Salem	1866-1872
William Little, Secretary	1866-1872
Thomas F. Wood, Secretary, Wilmington	1867-1872

THIRD BOARD

Charles J. O'Hagan, Greenville	1872-1878
W. A. B. Norcom, Edenton	1872-1878
C. Tate Murphy, Clinton	1872-1878
George A. Foote, Warrenton	1872-1878
J. W. Jones, Tarboro	1872-1878
R. L. Payne, Lexington	1872-1878
Charles Duffy, Jr., Secretary, New Bern	1872-1878

FOURTH BOARD

Peter E. Hines, Raleigh	1878-1884
Thomas D. Haigh, Fayetteville	1878-1884
George L. Kirby, Goldsboro	1878-1884
Thomas F. Wood, Wilmington	1878-1884
Joseph Graham, Charlotte	1878-1884
Robert I. Hicks, Williamston ¹	1878-1880
Richard H. Lewis, Raleigh ²	1880-1884
Henry T. Bahnson, Secretary, Salem	1878-1884

FIFTH BOARD

William R. Wood, Scotland Neck	1884-1890
Augustus W. Knox, Raleigh	1884-1890
Francis Duffy, New Bern	1884-1890
Patrick L. Murphy, Morganton	1884-1890
Willis Alston, Littleton	1884-1890
J. A. Reagan, Weaverville	1884-1890
W. J. H. Bellamy, Secretary, Wilmington	1884-1890

SIXTH AND SEVENTH BOARDS³

R. L. Payne, Jr., Lexington	1890-1892
George W. Purefoy, Asheville	1890-1892
George G. Thomas, Wilmington	1890-1894
Robert S. Young, Concord	1890-1894
William H. Whitehead, Rocky Mount	1890-1896
George W. Long, Graham	1890-1896
L. J. Picot, Secretary, Littleton	1890-1896
Julian M. Baker, Tarboro	1892-1898
H. B. Weaver, Secretary, Asheville	1892-1898
J. M. Hays, Greensboro ⁴	1894-1897
Kemp P. Battle, Jr., Raleigh ⁵	1897-1900
Thomas S. Burbank, Wilmington ¹	1894-1898
Richard H. Whitehead, Chapel Hill ⁴	1896-1898
William H. H. Cobb, Goldsboro ⁶	1893-1900
J. Howell Way, Secretary, Waynesville ⁷	1898-1902
David T. Tayloe, Washington	1896-1902
Thomas E. Anderson, Sec., Statesville	1896-1902
Albert Anderson, Wilson ⁸	1896-1902
Edward C. Register, Charlotte ⁸	1898-1902
Thomas S. McMullan, Hertford ⁸	1900-1902
John C. Walton ⁵	1900-1902

EIGHTH BOARD

A. A. Kent, Lenoir	1902-1908
Charles O'H. Laughinghouse, Greenville	1902-1908
M. H. Fletcher, Asheville	1902-1903
James M. Parrott, Kinston	1902-1903
J. T. J. Battle, Greensboro	1902-1908
Frank H. Russell, Wilmington	1902-1908
George W. Pressly, Secretary, Charlotte ¹	1902-1906
G. T. Sikes, Secretary, Grissom ⁴	1906-1908

NINTH BOARD

Lewis B. McBrayer, Asheville	1908-1914
John C. Rodman, Washington	1908-1914
William W. McKenzie, Salisbury	1908-1914
Henry H. Dodson, Greensboro	1908-1914
John Bynum, Winston-Salem	1908-1914
J. L. Nicholson, Richlands	1908-1914
Benj. K. Hays, Secretary, Oxford	1908-1914

TENTH BOARD

Isaac M. Taylor, Morganton	1914-1920
John Q. Myers, Charlotte	1914-1920
Jacob F. Highsmith, Fayetteville	1914-1920
Martin L. Stevens, Asheville	1914-1920
Charles T. Harper, Wilmington ¹	1914-1915
Edwin G. Moore, Elm City ¹⁰	1915-1920
John G. Blount, Washington ¹¹	1914-1920
Hubert A. Royster, Secretary, Raleigh	1914-1920

ELEVENTH BOARD

Lester A. Crowell, Lincolnton	1920-1926
William P. Holt, Duke	1920-1926
J. Gerald Murphy, Wilmington	1920-1926
Lucius N. Glenn, Gastonia	1920-1926
Clarence A. Shore, Raleigh	1920-1926
William M. Jones, Greensboro	1920-1926
Kemp P. B. Bonner, Sec., Morehead City	1920-1926

TWELFTH BOARD

Paul H. Ringer, Asheville	1926-1932
W. Houston Moore, Wilmington	1926-1932
T. W. M. Long, Roanoke Rapids	1926-1932
W. W. Dawson, Grifton ⁴	1926-1930
J. K. Pepper, Winston-Salem	1926-1932
Foy Roberson, Durham	1926-1932
John W. McConnell, Secretary, Davidson	1926-1932
David T. Tayloe, Jr., Washington ¹²	1930-1932

THIRTEENTH BOARD

Ben F. Royal, Morehead City	1932-1938
Benj. J. Lawrence, Secretary, Raleigh	1932-1938
F. Webb Griffith, Asheville	1932-1938
Hamilton W. McKay, Charlotte	1932-1938
J. W. Vernon, Morganton	1932-1938
W. H. Smith, Goldsboro	1932-1938
K. G. Averitt, Cedar Creek ¹	1932-1936
Roscoe D. McMillan, Red Springs ¹³	1936-1938

¹ Resigned before expiration of term.

² Elected for unexpired term of Dr. Hicks.

³ In 1890 the Medical Society of the State of North Carolina adopted the plan of electing members of the Board in such a manner that the terms would expire at different intervals of two years. This practice was followed for twelve years, or until 1902, when the plan was abandoned, an equivalent of two terms of six years each. It is evident that the Society arranged to abandon the policy as early as 1898, as two members were elected for short terms, and two years later two other members were elected for still shorter terms. It is therefore impossible to separate the sixth and seven Boards, since the membership was overlapping.

⁴ Died before the expiration of his term.

⁵ Elected to serve unexpired term of Dr. Hays.

⁶ Elected to serve the unexpired term of Dr. Burbank.

⁷ Elected to serve the unexpired term of Dr. Whithead.

⁸ Elected for short term expiring in 1902.

⁹ Elected to serve the unexpired term of Dr. Pressly.

¹⁰ Elected to serve the unexpired term of Dr. Harper.

¹¹ Died a few months before the expiration of his term; such a short time that the vacancy was not filled.

¹² Elected to serve unexpired term of Dr. W. W. Dawson.

¹³ Elected to serve unexpired term of Dr. Averitt.

FOURTEENTH BOARD

Karl B. Pace, Greenville	1938-1944
William M. Coppridge, Durham	1938-1944
Frank A. Sharpe, Greensboro	1938-1944
Lewis W. Elias, Asheville ¹	1938-1943
J. Street Brewer, Roseboro	1938-1944
W. D. James, Secretary, Hamlet	1938-1944
L. A. Crowell, Jr., Lincolnton	1938-1944
John LaBruce Ward, Asheville ¹⁴	1943-1944

FIFTEENTH BOARD

C. W. Armstrong, Salisbury	1944-1950
Paul G. Parker, Erwin	1944-1950
M. D. Bonner, Jamestown	1944-1950
T. Leslie Lee, Kinston	1944-1950
Roy B. McKnight, Charlotte	1944-1950
M. A. Pittman, Wilson	1944-1950
Ivan M. Procter, Secretary, Raleigh	1944-1950
James B. Bullitt, Chapel Hill ¹⁵	1949-1950
Paul F. Whitaker, Kinston ¹⁶	1950

SIXTEENTH BOARD

Amos N. Johnson, Garland	1950-1956
Heyward C. Thompson, Shelby	1950-1956
James P. Rousseau, Winston-Salem	1950-1956
Newsom P. Battle, Rocky Mount	1950-1956
Clyde R. Hedrick, Lenoir	1950-1956
L. Randolph Doffermeyer, Dunn	1950-1956
G. Westbrook Murphy, Asheville ¹⁷	1955
Joseph J. Combs, Secretary, Raleigh	1950-1956

SEVENTEENTH BOARD

Carl Vann Tyner, M.D., Leaksville	1956-1962
Joseph John Combs, M.D., Raleigh	1956-1962
John Bascom Anderson, M. D., Asheville	1956-1962
Thomas Williams Baker, M.D., Charlotte	1956-1962
Edwin Albert Rasberry, Jr., M.D., Wilson	1956-1962
Thomas G. Thurston, M.D., Salisbury	1956-1962
Luther Randolph Doffermeyer, M.D., Dunn	1956-1962

14 Elected to serve unexpired term of Dr. Elias.

15 Elected to serve unexpired term of Dr. T. Leslie Lee.

16 Elected to serve unexpired term of Dr. Paul G. Parker.

17 Elected to serve unexpired term of Dr. James P. Rousseau.

MEDICAL AWARDS

MOORE COUNTY MEDICAL SOCIETY MEDAL

In 1927 the Moore County Medical Society established a fund, the interest from which is used to pay for a medal to be given for the best paper read at the State Society meeting each year. No one is eligible to receive this medal except Fellows of the Medical Society of the State of North Carolina in good standing; no invited guest is allowed to compete.

Each Section Chairman selects a committee of three to decide on the best paper written in their section. The winning papers are then turned over to the State Committee, who select the one to receive the medal. The following Fellows have been awarded this medal:

1928—Paul Pressly McCain, M.D. Sanatorium
"The Diagnosis and Significance of Juvenile Tuberculosis"

(From Section on Pediatrics)

1929—A. B. Holmes, M.D. Fairmont

"The Treatment of Uremia"

(From Section on Chemistry, Materia Medica and Therapeutics)

1930—C. T. Smith, M.D., and W. Bernard Kinlaw, M.D. Rocky Mount

"The Clinical Consideration of Anaemia of Pregnancy and of Puerperium"

(From Section on Practice of Medicine)

1931—F. C. Smith, M.D. Charlotte

"Practical Value of Perimetry in Intracranial Conditions; Case Reports" (tumors, vascular disease, toxemia, syphilis and trauma.)

From Section on Eye, Ear, Nose and Throat)

1932—Charles I. Allen, M.D. Wadesboro
"An Improved Splint for Treating Fractures of the Lower Extremity Showing Reduction and Skeletal Distraction Attachments"

(From Section on Surgery)

1933—H. L. Sloan, M.D. Charlotte

"Some General Remarks about Cataract Surgery, With Report of 100 Consecutive Uncomplicated Cataract Operations"

(From Section on Ophthalmology and Otolaryngology)

J. R. Adams, M.D. Charlotte

"Hypo-glycaemia in Children"

(From Section on Pediatrics)

1934—Fred E. Motley, M.D. Charlotte

"Complications of Mastoiditis with Special Reference to Septicemia"

(From Section on Ophthalmology and Otolaryngology)

1935—Arthur H. London, M.D. Durham

"The Composition of an Average Pediatrics Practice"

(From Section on Pediatrics)

1936—V. K. Hart, M.D. Charlotte

"Etiological and Therapeutic Aspects of Bronchiectasis with Clinical Observations on Bronchial Lavage by the Stitt Method"

(From Section on Ophthalmology and Otolaryngology)

1937—No award made.

1938—O. Hunter Jones, M.D. Charlotte

"Pelvic Architecture and Classification with its Practical Application"

(From Section on Gynecology and Obstetrics)

1939—Donnell B. Cobb, M.D. Goldsboro

"Vaginal Ureterolithotomy"

(From Section on Surgery)

1940—C. R. Monroe, M.D., C. D. Thomas, M.D., and C. L. Gray, M.D. Pinehurst

"Thoracoplasty and Apicolysis"

(From Section on Surgery)

1941—Walter R. Johnson, M.D. Asheville

"Is Diverticulitis of the Colon a Surgical Disease?"

(From Section on Practice of Medicine)

1942—E. P. Alyea, M.D. Durham

"Castration for Carcinoma of the Prostate Gland"

(From Section on Surgery)

1943—No award made.

1944—D. F. Milam, M.D. Chapel Hill

"Vitamin C Content of Some North Carolina Cooked Foods"

(From Section on Public Health and Education)

1945—No Meeting.

1946—E. C. Hamblen, M.D. Durham

"Some Aspects of Sex Endocrinology in General Practice"

(From Section on General Practice of Medicine and Surgery)

1947—W. L. Thomas, M.D. Durham

"Some Psychosomatic Problems in Gynecology"

(From Section on Gynecology and Obstetrics)

1948—Felda Hightower, M.D. Winston-Salem

"The Control of Electrolyte and Water Balance in Surgical Patients"

(From Section on Surgery)

1949—George J. Baylin, M.D. Durham

"The Roentgen Aspect of Non-Opaque Pulmonary Foreign Bodies"

(From Section on Radiology)

1950—Parker R. Beamer, M.D. Winston-Salem

"Studies on Experimental Leptospirosis"

(From Section on Pathology)

- 1951—John P. U. McLeod, M.D. Marshville
 "A Simplified Modification for Staining of the
 Vaginal Smear for Immediate Appraisal of
 Endocrine Activity"
 (From Section on Gynecology and Obstetrics)
- 1952—Samuel F. Ravenel, M.D. Greensboro
 "Humidification in Pediatrics"
 (From Section on Pediatrics)
- 1953—Harrie R. Chamberlin, M.D. Chapel Hill
 "Diagnosis and Management of Poisoning Due
 to Organic Phosphate Insecticides"
 (From Section on Pediatrics)
- 1954—Paul Kimmelstiel, M.D. Charlotte
 Roland T. Pixley, M.D. Charlotte
 John Crawford, M.D. Charlotte
 "Statistical Review of Twenty-two Thousand
 Cases Examined by Cervical Smears"
 (From Section on Pathology)
- 1955—H. Hugh Bryan, M.D. Chapel Hill
 "Obesity and the Public Health"
 (From Section on Public Health)
- 1956—Wm. M. Peck, M.D. McCain
 "The Changing Pattern of Tuberculosis"
 (Section PH&E)
- 1957—John R. Ashe, Jr., M.D. Concord
 John V. Arey, M.D. Concord
 "The Use of Diamox in Obstetrics and
 Gynecology"
 (From Section on Obstetrics and Gynecology)
- 1958—John O. Lafferty, M.D.
 "Peptic Ulcers in Children"
 (From Section on Radiology)
- 1959—Robert E. Coker, Jr., MD. Chapel Hill
 "The Medical Student and Specialization"
 (From Section on Public Health & Education)

THE GEORGE MARION COOPER AWARD

The Fellows of the Wake County Medical Society present this George Marion Cooper Award established in honor of George Marion Cooper, physician and health benefactor.

This medal is awarded by the Fellows of the Wake County Medical Society as a token of appreciation and esteem in recognition of the eminence of an essay contributing to the knowledge and advancement of the science of medicine in the field of Preventive Medicine, Public Health, or Maternal and Infant Health Care, presented before the Medical Society of the State of North Carolina. The following Fellows have been awarded this medal:

- 1951—Donald L. Whitener, M.D. Winston-Salem
 "The Management of Labor and Delivery in
 the Interest of the Premature Infant"
 (From Section on Gynecology and Obstetrics)
- 1952—Ronald Stephen, M.D. Senior Author;
 Duke University. Durham
 "The Evaluation of Methods of Pain Relief
 During Labor and Delivery with Reference
 to Mother and Child."
 (From Section on Gynecology and Obstetrics)
- 1953—Ernest Craig, M.D. Chapel Hill
 "The Prevention of Recurrences of Rheumatic
 Fever"
 (From the Section on Practice of Medicine)
- 1954—Richard L. Pearse, M.D. Durham
 Eleanor Easley, M.D. Durham
 Kenneth Podger, M.D. Durham
 "Obstetric Analgesia and Anesthesia"
 (From Section on Obstetrics and Gynecology)
- 1955—Dirk Verhoeff, M.D. Huntersville
 William M. Peck, M.D. McCain
 "The Trends in Management of Tuberculosis
 in Children"
 (From Section on Pediatrics)
- 1956—Benjamin A. Johnson, M.D. Durham
 Susan C. Dees, M.D. Durham
 "Immunization of Allergic Children with Partic-
 ular Reference to Eczema Vaccinatum"
 (Section on Pediatrics)
- 1957—Walter A. Sikes, M.D. Raleigh
 John D. Patton, M.D. Asheville
 Robert L. Craig, M.D. Asheville
 Marle Baldwin, M.D. Asheville
 Anne Sagberg, M.D. Asheville
 R. Charman Carroll, M.D. Asheville
 "Trends in the Development of an Open Psy-
 chiatric Hospital"
 (From Section on Neurology and Psychiatry)
- 1958—Madison S. Spach, M.D.
 Jerome S. Harris, M.D.
 "Congenital Heart Disease in Infancy"
 (From Section on Pediatrics)
- 1959—Roy T. Parker, M.D. Durham
 Harry W. Johnson, M.D. Durham

- F. Bayard Carter, M.D. Durham
 "Obstetric Shock"
 (From Section on General Practice of Medicine)

GASTON COUNTY MEDICAL SOCIETY AWARD

By authority of the House of Delegates an award is established by the Gaston County Medical Society for the best presentation of audio-visual material in scientific treatise and will be awarded to the best presentation annually at the Annual Session of the State Society. Competition will be restricted to audio-visual material as provided by the rules. Program Chairmen of the eleven scientific sections should take note of this in the preparation of the 1956 program and in judging of presentations at the Annual Session in 1956. The following Fellows have been awarded this medal:

- 1952—Kenneth L. Pickrell, M.D. Durham
 "Tattooing the Cornea"
 (From Scientific Exhibits)
- 1953—Joseph E. Markee, M.D. Durham
 "Autonomic Nervous System"
 (Film from Audio-Visual Postgraduate
 Instructional Program)
- 1954—William H. Boyce, M.D. Winston-Salem
 Fred K. Garvey, M.D. Winston-Salem
 Charles M. Norfleet, M.D. Winston-Salem
 "Biocolloids of Urine in Health and in Calculous
 Disease"
 (From Scientific Exhibits)
- 1955—Caleb Young, M.D. Winston-Salem
 "Congenital Dislocation of the Hip"
 (A motion picture)
 (From Postgraduate Audio-Visual Program)
- 1956—C. R. Stephen, M.D. Durham
 R. C. Martin, M.D. Durham
 Bourgeois-Gavardin. Durham
 "Prophylaxis of Non-Hemolytic Transfusion
 Reactions: Value of Pyribenzamine"
 (Section on Anesthesia)
- 1957—J. Leonard Goldner, M.D. Durham
 Mr. Bert Titus Durham
 "The Juvenile Amputee-Upper Extremity"
 (From Section on General Practice of Medicine)
- 1958—T. Franklin Williams, M.D.
 J. L. DeWalt, M.D.
 R. W. Winter, M.D.
 Charles H. Burnett, M.D.
 "Newer Diagnostic Criteria In Hyperparathy-
 roidism"
 (From 1958 Scientific Exhibits)
- 1959—Albert G. Smith, M.D. Durham
 "Automation in the Clinical Chemistry
 Laboratory"
 (From Section on Pathology)

EXECUTIVE COUNCIL MEETINGS

SATURDAY AFTERNOON SESSION

May 7, 1960

The first meeting of the Executive Council was held in connection with the One Hundred and Sixth Annual Session of the Medical Society of the State of North Carolina, at two o'clock at the Sir Walter Hotel, Raleigh, North Carolina, President John C. Reece presiding.

PRESIDENT REECE: recognized Dr. George Paschal who opened with prayer.

Dr. John S. Rhodes, the Secretary, called the roll and sixteen members of Council being present a quorum was declared.

PRESIDENT REECE: We declare a quorum present and will proceed with the business at hand.

First, since this is the last Executive Council that it will be my privilege and pleasure to preside over, I wish to express to you sincere appreciation for the services and support that you have given me in the past year. It has been a real honor and privilege and pleasure to work with all of you. My interest in the Medical Society and organized medicine will continue as long as I live, and if I can be of additional service to this organization at any time, I will certainly be available.

We have with us at this time several guests that I would like to recognize. First, Mr. Dick Nelson representing the Field Service of the American Medical Association. We are delighted to have you with us.

Dr. Westbrook Murphy, we are delighted to have you present with us and we welcome you, and any time that you wish to stay here or enter in our deliberations and discussion, please feel free to do so.

Dr. Bivens as Seventh District Councilor is here and we are delighted to have him.

We will make some announcement later if it is necessary for us to have an Executive Session or any discussion.

Our agenda is a rather long one, but it deals mostly with detailed reports that will be in the manuscripts and the protocols that have been distributed. Please feel free to bring up any point that you would like. When we are discussing problems, let us keep our discussion to the subject that is at hand.

Our plans are to reconvene at nine or nine-thirty in the morning. We have invited members of the Board of Trustees of the Hospital Savings and the Hospital Care to be with us at that time to hear Dr. Donald Stubbs speak on our Blue Shield program.

We go now to abridged report of Council

interim Procedures, Mr. Barnes.

MR. BARNES: Well, I have the reporter's transcript of near four hundred pages of reports of the two meetings of September 27, 1959 and January 31, 1960, both of which have been abridged in a report prepared for Dr. Reece's signature, which has gone to each member of the Council and to all the delegates of the State Society in the material that was sent out last week. I think it is a question of approving that unless somebody finds something to object to.

PRESIDENT REECE: I will state this: I have gone through the abridgment; I did not go through all of this, but I took Jim's efforts, and I have been through the abridgment of the last two Executive Councils in detail and I find them in order as well as my memory serves me, and from the transcripts that were at hand. What is your pleasure? Do you want them all read again, or do we accept them?

DR. SQUIRES: I move that we accept them as information.

[The motion was seconded by Dr. Garrison, was put to a vote and carried.]

PRESIDENT REECE: We have Dr. Bob Andrews with us. He represents the newly formed North Carolina Association of Blood Banks. Dr. Andrews is a pathologist from Lumberton and is very much interested in the Blood Bank Organization in the State of North Carolina, and he wishes to outline briefly for the Executive Council the plans and organization of this blood bank. Dr. Andrews, you are recognized at this time.

DR. ANDREWS: Thank you, Dr. Reece. I am appearing before you here today to inform you of the North Carolina Association of Blood Banks and to ask your *endorsement* of this organization. We have been in the process of organizing this association for about a year now. The aims of this organization are similar to those of the American Association of Blood Banks and other State Associations of Blood Banks. Briefly, the aims that are listed in our articles of incorporation are as follows:

To expand blood banking facilities to meet the needs for blood and its derivatives for every person in the State of North Carolina.

To promote and foster the exchange of ideas and material and information relating to blood banking and transfusion services, and to foster and develop a clearing house or an organization for the exchange of blood or credits within and without this state, and then also to assist in the organization of

new blood banks, or to provide assistance in the means of technical aid to already organized blood banks.

It is the plan of this association to accomplish these purposes in the following way:

Number 1, to establish standards for blood banking practices in our state, and these will be based on nationally recognized standards, such as the minimum standards as approved by the National Institutes of Health and the standards approved by the American Association of Blood Banks.

Number 2, we would like to sponsor educational meetings in our state both for physicians and for technical personnel, and at first, this would probably be set up on the basis of an annual workshop for technical personnel.

Number 3, and this will be a long-range project, to make available for those blood banks who want a program for exchange of blood or blood credit in this state.

Now, in order to exchange blood or credits, it is going to be necessary to have banks meet the minimum standards that the organization sets up. We would have to set up an accreditation and section program through the state, and for those blood banks who would like to exchange blood or credits and want to meet these standards, we would provide the framework for this organization. Similar organizations are in existence in other states and on the national level.

Both our general purposes, the educational and the exchange of credits, are designed to meet the best interests of the patients who are needing transfusions in this state.

The organization is set up as a non-profit corporation and it has memberships of four types: (1) blood banks who have full-time medical directors, (2) blood banks which do not have full-time medical directors, (3) institutions who are interested in the blood banking facility in some way but are not clearly operating a blood bank, and (4) individuals. Voting in this organization would be limited to the first two types of blood bank membership.

The association is governed by an eight-man Board of Directors. Six of these directors would be elected by the organization, and two to be appointed, one from the North Carolina Hospital Association, and one from the North Carolina Society of Pathologists.

The fees would be determined by the number of donors that the participating blood banks draw which would range from \$15 for banks drawing less than a thousand donors to \$50 for those banks drawing more than five thousand donors.

We hope that this will be a successful organization, that it can help to meet our

blood banking needs in the state, and I would ask your approval of this organization. Thank you.

DR. SAMS: I move you, sir, that we endorse the blood bank as reported by the doctor and forward it to the House of Delegates for their consideration.

PRESIDENT REECE: The motion has been made that we endorse the establishment of this blood bank and that we recommend to the House of Delegates that they approve.

DR. PASCHAL: I second the motion.

[There were calls for the question.]

PRESIDENT REECE: All in favor. Any opposed? It is carried. Thank you, Dr. Andrews.

PRESIDENT REECE: Regarding life membership, several county medical societies have resolutions and letters concerning this same problem, so we might discuss all of these together at the present time.

MR. BARNES: I have here, received on February 24, from the Harnett County Medical Society a memorandum which reads:

To: County Medical Societies of the State of North Carolina

From: The Harnett County Medical Society

Date: February 19, 1960

Subject: By-Laws Establishing Life Membership

The Harnett County Medical Society at a regular monthly meeting went on record as opposing the By-Laws passed by the House of Delegates of 1958 and ratified in 1959 for establishing life membership for members of the Medical Society of the State of North Carolina. The present criterion is that an individual shall have reached the age of 70 years and consecutively been a member of and paid state society dues for a period of 20 years.

The Harnett County Medical Society opposes this action for two main reasons:

1. The Society does not feel that a person who has already received a life membership certificate in the State of North Carolina should be taken out of the category of a life member. The Society feels that if a member has attained a life membership certificate by practicing medicine in the State of North Carolina for 30 years, that that individual should not be deprived of life membership. We do not believe that by law that this honor can be taken away from a member. We are sure there are several members who fall into this category.

2. The second reason that we are opposed to this change in the By-Law is

that the Society feels that the age limit should be 65 instead of 70 years as all other professions and businesses use 65 years as a retirement age.

The Harnett County Medical Society hopes that each county society in the State of North Carolina will take appropriate action and cause the House of Delegates to change the By-Laws to cover the above changes.

Sincerely,
Charles W. Byrd, M.D.
Secretary
February 24, 1960

That was acknowledged and they were advised it would be put on the agenda.

I believe the only other formal action has come from the Wilson County Medical Society, in which they simply directed a letter to the Medical Society of the State of North Carolina, stating they approve this Harnett County resolution. I believe no other society has taken a formal action and presented it to the State Society for consideration.

We have a list of some fifteen to twenty names of individual doctors who have been life members of the State Society and who have written in some critical letters as to why their status has been changed when they hold a life membership or honorary fellowship certificate stating that they would be exempt from the payment of dues for the rest of their lives. So it is apparent that there is some limited segment of the 540 people last year involved in this life status who did not understand that there had been a change made in the By-Laws and Constitution, as required by two consecutive annual meeting actions of the House of Delegates.

Now I don't think you would want all these letters read. They are here if anybody would like to see them. Some of them simply annotated the back of a letter we sent them in regard to their dues and said "I understood I was a life member. Why do I get this?" That is about the extent.

I made a little analysis, if this is proper information, that of the 540 having life membership status a year ago, that is, during the year 1959, there are presently on the rolls 502. Of the 502, 252 have attained the age of 70, and therefore are exempt in perpetuity from the payment of dues. That leaves 250 that dues would be required of because of a changed status effected by the revised By-Laws. Of that number, 165 have paid those dues and 78, I believe, have not paid dues for the current year.

What is involved is roughly about 70 people who have seen fit not to pay their dues and who may appear at the registration counter tomorrow or the next day or

so on throughout the convention and demand registration. Administratively, we have the problem of how we handle those people.

This Council several years ago ruled and instructed us in conducting the registration at the annual meeting to register any unpaid physician, that is, a physician who is required to pay dues, as a guest of the Society. So we have some few unpaid members who are not related to life membership whatever, and then we have three 78 former life members who have not paid dues for the current year, and we would like you to tell us what to tell them when we face them at registration.

DR. GARRISON: Wasn't the provision you made in there one that if a man was not active at that particular age to make a certain amount of money, if there was hardship, that he didn't have to pay. That made it clear that if a man was in active practice, you expected him to pay his dues.

SECRETARY RHODES: At the Council meeting last fall (1959), George Paschal and Jim Barnes and I were appointed as a committee by the Council to review these hardship cases of men (Life Members) who were inactive or disabled by illness. We have had quite a few of those, and we have certainly tried to be fair in interpreting them.

DR. PASCHAL: Mr. Chairman, may I speak to this point so that it might reflect some of the sentiment that I have heard voiced.

They asked me, did we not intend participation in the membership of the Society by the men that were involved in this age group to be carried out on a voluntary basis? It is my impression that that was not to be done, and I so informed them.

I further found out that there is considerable agitation on the part of several of the older men to employ counsel and to make a test case out of this thing, and to bring it up through the courts to have some satisfaction as far as their position is concerned. There are some that are adamant about it and want to do that. Others prefer to take a more mild course and ask that it be considered by the Council and some satisfactory arrangement for these members be made.

These people contend that this prior arrangement represents a contract which cannot be broken, and some of them are prepared to resist it and demand their full privileges, as they were under the former Constitution.

What this body wants to do about it. I don't know. As you have pointed out, we do

have 250 members who now come under the provisions of this change; 165 of these have paid. Some of them have paid under protest. I have been informed.

MR. BARNES: That is correct.

DR. PASCHAL: I don't know whether this is the place for a suggestion or not. My suggestion would be for this group of people to make their participation on a voluntary basis, and those who do want to, let them not participate. Each year, as time goes on, we will find more that will come under this group, that will meet the requirements for life membership, and we will not be faced with that problem.

I think that on the basis of public relations and good harmony within the Medical Society itself, that it might be well to consider making it possible for these people to participate on a voluntary basis.

DR. AMOS JOHNSON: I would make a motion then that this Council go on record as interpreting Chapter I, Section 3 of its By-Laws to mean that it does not affect, those who are now in possession of life membership. However, they may, of their own volition, pay their dues until the time set forth to fit the specification set forth in the action of the House of Delegates 1958-59.

[The motion was duly seconded by Dr. Koonce.]

DR. KOONCE: May I ask a question? Do you leave that up to the approval of the House of Delegates? It will have to be reported to them.

DR. AMOS JOHNSON: I think actually all we do here today is basically reported to the House of Delegates.

DR. KOONCE: May I ask my question? If this is done by the Executive Committee as a recommendation to the House of Delegates, it would pretty well obviate the Harnett County resolution, wouldn't it?

PRESIDENT REECE: I would think so, yes.

DR. KOONCE: Therefore, if the House of Delegates wants to vote on the recommendation of the Executive Committee, it would obviate that resolution. The reason I am asking that is this: According to our new By-Laws, any resolution that comes before the House on Monday has to go before a Resolutions Committee to be considered and discussed, and a recommendation from the Resolutions Committee comes back on Tuesday for ratification.

Therefore, if it is going to be left up to the resolution of Harnett County, it would have to come back Tuesday. If it comes as a recommendation from the Executive Committee, it could be voted on Monday and passed.

DR. AMOS JOHNSON: The Executive Committee has power to act in the interim between meetings of the House of Delegates.

SECRETARY RHODES: I would like to make one point. I think in presenting this to the House of Delegates, it should be distinctly pointed out that this is a charge in interpretation, and the administrative office hasn't been at fault in this matter. Furthermore, I think it ought to be specifically stated that this becomes effective as of January, 1960, because that would be the effective date, as I understand it.

DR. PASCHAL: I would also suggest that we make an appeal to the membership, this group that is involved, to point out to them that this is to be done on a voluntary basis, but make an appeal to them to continue the payment of their dues in supporting our organization, because we do need that money. Possibly if that were done at the same time, it might serve some useful purpose, and make them feel a little more inclined to continue to pay and not to ask for any reimbursement.

PRESIDENT REECE: We know when we passed this thing several years ago that many people who were gainfully employed in the practice of medicine were very willing to start paying dues again; in fact, the majority did, and that was expressed time and time again by men like Dr. Sams and Dr. Raby that was on the Council years ago. He pointed out that he was in a much better position to pay dues now than he was when he started a long time ago, and much better than his son who was practicing in Charlotte and just starting out, and he was willing and glad to do it.

I think that should be strongly brought out when this is presented tomorrow. I think we should encourage those who are gainfully employed in the practice of medicine to continue paying their dues.

[Calls for the question.]

PRESIDENT REECE: You have heard the motion, and it is seconded. All in favor say "aye"; any opposed? It is carried.

DR. KOONCE: With the permission of this Council, I will put it on the agenda of the House of Delegates under the report of the Executive Committee and call on you for it.

PRESIDENT REECE: Yes, sir.

We come now to Item (b), memorandum from Wake County Medical Society, hosting and entertainment.

MR. BARNES: This is a memorandum from the Wake County Medical Society to the State Society:

It will be the pleasure of the Wake County Medical Society to be host to the

Medical Society of the State of North Carolina at its Annual Sessions May 8 to 11, 1960. It has been decided by our group that the entire County Society should act as a Committee of the Whole to help in a welcoming capacity and make our guests feel at home.

To this end, your entertainment committee is asking that each of you make yourself available for as much time as possible during this four-day period. An identifying ribbon will be issued to you on your request when you register for the meeting in the front lobby of the William Neal Reynolds Coliseum.

Enclosed is a return post card on which we hope you will indicate your availability and willingness to serve with spaces provided for you to check off the times you wish to contribute to this effort. This need includes the President's Banquet and Ball on Tuesday evening, May 10, 1960.

We hope that the meeting will be of sufficient success in Raleigh that the membership of the State Society will wish to return here frequently as a place of the Annual Meeting. Certainly we members of the Wake County Society can contribute to their interest and desire to return to Raleigh for the Annual Meeting.

Your Committee is counting on your cooperation.

Sincerely yours,
LOCAL ENTERTAINMENT
COMMITTEE

Robert J. Ruark, M.D., Chairman
P. G. Fox, M.D.

Gordon Sinclair, M.D.

L. H. Sanders, M. D.

Lunsford Long, M.D.

Hugh McManus, M.D.

James Wright, M. D.

PRESIDENT REECE: You have heard the memorandum. What is your pleasure?

DR. AMOS JOHNSON: I move it be accepted.

[The motion was duly seconded by Dr. Beddingfield.]

PRESIDENT REECE: All in favor say "aye"; opposed "no." It is carried.

The letter from Stanly County Medical Society. I see that I am to discuss it, and also Dr. Squires and I have been in on this discussion.

We hope right at present this is a situation that is settled.

DR. CLAUDE B. SQUIRES: I think this matter has been settled with reference to some action of the Committee of the Stanly County Medical Society. I think the doctor involved has informed me twice that he didn't choose to pursue it any further.

PRESIDENT REECE: Apparently, Dr.

Mees committee feels that problem has been solved. I referred this to Dr. Squires, and his Councilor for the district, and feel he has arrived at a satisfactory solution to it.

A letter from Dr. Vance is next.

Mr. BARNES: This is a letter from Dr. S. W. Vance of Pineola, North Carolina, it reads:

'Relative to my present status as a member of the Avery County Medical Society, let me explain that I am on emergency leave from Africa, where I have been engaged in Medical Mission work. In October of 1957, the North Carolina State Medical Society paid me the honor of granting me Honorary membership. Since my son came down with acute (illness) and my temporary return to the U.S.A., I have accepted temporarily some work with the State Board of Health in the capacity of Health Officer of the County; However, I am still under active status with the Foreign Mission Board, committed to return as soon as possible.

In view of these facts, I should like to request that you bring before the Society my request to be carried during 1960 as an Honorary member, until such time as my return to the Mission Field may be accomplished.

Respectfully yours,
S. W. Vance, M.D.

DR. SAMS: Mr. President, Dr. Vance formerly practiced medicine in my town and went from that to the Mission Field, and I made the motion before this Council that he be allowed his present status.

DR. BEDDINGFIELD: I am a little more sensitive about public relations than others.

I think we can go along with him for one year according to his request, if he stays there; we can say we will go along with him on this one-year basis because of extenuating circumstances. However, it is our policy in general in employment, that we expect you to pay dues.

DR. SAMS: I'll go along with that as a seconding.

PRESIDENT REECE: You will accept that, that we answer his letter in those terms.

You have heard the motion. All in favor say "aye"; opposed "no." The motion is carried, and it is understood how we are to answer that letter.

DR. PASCHAL: Our counsel, Mr. Chairman, points out one thing that might precipitate some argument at the time our recommendation is presented to the House of Delegates, and this pertains to a matter we have previously considered concerning this life membership thing.

There will be those who have 29 years of

service, so to speak, in the Society, and under the provisions of their old contract, it will serve as possibly a point of argument for those that are in that group; but if we would make a recommendation coming from this Council to the effect that the men that are in that group will be expected to pay, it might simplify the thing, rather than waiting and letting it get to the floor and having an argument there.

I make a motion, if I am permitted, that we support a resolution to the effect that we expect the members that have not yet served their 30 years to participate in the new provision, such as is described now in our By-Laws (Chap. I, Section 3).

[The motion was duly seconded by Dr. Sams.]

MR. BARNES: What you are doing, Dr. Paschal, is getting in the record a statement that any claimed vested interest in a life membership based on the old provisions of the Constitution and By-Laws did not extend to any members who had not attained that as of January 1, 1959.

DR. PASCHAL: That's the idea.

PRESIDENT REECE: In other words, our life membership applied only to when you attained the age of 70, and you must have been a dues-paying member for 20 years. You have heard the motion. It has been restated a second time. Does everyone understand it?

[The motion was put to a vote and carried.]

Item (c) concerning Alleghany County.

MR. BARNES: Gentlemen, this item was on the agenda, and it involves a request of the component society in the 8th Medical District. Dr. Bonner, you were not present at that meeting, so the Council deferred action until this meeting today.

This is a letter dated November 19, 1959, addressed to me from Dr. G. J. Ashley of Sparta, North Carolina, and it reads as follows:

The four Alleghany County members of the Wilkes-Alleghany Medical Society have expressed a desire to withdraw from the present society and form a new society with the Ashe County.

The Ashe County group is small; we seem to have more mutual interest; geographically Ashe and Alleghany are similar and the distance is closer. Frankly, none of us in the present Society to which we belong have been very active.

We from Alleghany have met with the Ashe physicians on two occasions; the proposed change has been discussed thoroughly and is made by mutual agreement.

I have contacted Dr. Bonner, our District

Councilor, and he advised me to write you explaining our situation and wishes. He said you would advise us as to what procedure to take to achieve these changes.

We would appreciate any advice you could give us. Thank you very much.

We instructed him that he should get the permission of the Wilkes-Alleghany Society, as well as a formal expression of the Ashe County group, to form this hyphenated society, and it is up to you to authorize it, because it is a By-Law item and has to be changed by the House of Delegates.

DR. SAMS: I think we ought to hear from Dr. Bonner on that.

DR. MERLE D. BONNER: He told you all I know about it.

PRESIDENT REECE: Is there any reason why the request should not be considered?

DR. BONNER: Didn't Harry Johnson get in touch with you? Harry is Vice Councilor, and he sort of looks after that.

DR. SAMS: Is there any friction about the thing from Wilkes County?

DR. BONNER: Not as far as I know, no objection to it.

DR. SAMS: I move that permission be granted for them to pull away from Wilkes and join the Alleghany-Ashe Society.

PRESIDENT REECE: You have heard Dr. Sam's motion. Is there a second?

[The motion was duly seconded by Dr. Bonner, put to a vote and carried.]

PRESIDENT REECE: Section (i), letter from Dr. Blasingame.

MR. BARNES: Gentlemen, this is a communication from the Executive Director of the American Medical Association, and it has to do with the subject of a national group annuity program, and an American Medical Association group disability insurance program.

They submitted along with the letter a survey form which I filled out and returned to them giving the status of our insurance programs in the State at the present time, and the fact that we had a committee studying a plan for annuities, that is from the standpoint of laying aside from current income certain amounts in trust funds if the Keogh-Simpson Bill was to be passed.

I believe that committee is to make report to either the Council or the House of Delegates at this meeting, but in substance I reported that we could not find favor for an American Medical Association Health and Accident Insurance Program within the group in this State Society, and that we had this annuity study under way. After sending that report, I got a follow-up wire dated April 30th which inquired—it says “unless informed otherwise prior to May 6th, or re-

cept by that date of complete questionnaires concerning group annuity and disability programs, it will be interpreted you do not approve sponsorship of either program as appropriate AMA activity."

I wired him back "Our National Group Annuity Inquiry Blank was mailed to you under date of April 20th. Answer should be regarded no, unless our Executive Council decides otherwise on May 7th meeting in Raleigh."

DR. NORFLEET: I move that Mr. Barnes' telegraphic answer of "no" stands.

[The motion was duly seconded.]

[The motion was put to a vote and carried.]

PRESIDENT REECE: When you answer the letter, you might say if they have any real plans that are better, they might tell us about them, and we will be glad to listen to them.

We will go to Item (d) Committee on Radiation—State Board of Health, report by Dr. Reeves.

MR. BARNES: This is a letter from Dr. Robert J. Reeves, dated April 30th:

In reply to your letter of April 20th, it is correct I am on the Governor's Atomic Board of Control Committee for Radiation Protection in North Carolina and also accepted your kind invitation to serve on the State Board of Health with Dr. Wilson. The latter appointment unfortunately has not materialized into anything as yet and we have not had any problems as far as the ABC committee is concerned. I had one meeting with Mr. W. D. Carmichael sometime ago concerning radioactive waste which was to be dumped off shore from North Carolina out of New York State. This was cleared up and no hazards were found. I will be in Mexico City from May 2 through the 10th and unfortunately may miss the State meeting this year.

I would appreciate it if you would give a message to the Executive Council to this effect and state that I will soon get together with Dr. Wilson and we will start the program of requiring all people who use x-ray machines or any radioactivity to fill out the routine registration cards which the State Board of Health will send out and we will survey these to determine any hazards or danger to personnel or patients and attempt to correct these measures. This program, I understand, is going to be put into effect shortly.

Kindest regards,

Robert J. Reeves, M.D.

Committee on Radiation

PRESIDENT REECE: You have heard

the report. Is there any action other than to receive it as information?

DR. SAMS: I move it be received as information.

[The motion was duly seconded, put to a vote and carried.]

PRESIDENT REECE: The Committee on Nominations, Dr. Hubert Poteat to discuss.

DR. HUBERT POTEAT: Mr. President, I served now on the Committee for Nominations for two years, this last year as Chairman, and all of us have been impressed with the total apathy on the part of the average member of our Society in the offices of the Society, and the nominees for these various offices.

This last year I had one letter from one individual in my district relative to the nominations for the elected offices of our Society. The Nominating Committee considered this matter. Everyone else had substantially the same experience. As a matter of fact, I think 50 per cent of the letters that we received came from men in this room right now, and it is entirely possible that this Society is operated by a very small clique within the Society. If so, I think it is a good clique at this time.

However, in the future, I think you can see that if different people got in here, we would be in somewhat of a jam.

Therefore, the Nominating Committee recommends to you, sir, and to the Council, that additional duties be imposed on the Councilors, that of canvassing the County Medical Societies within their districts relative to their wishes for the elected officers, and those wishes be communicated to their representatives on the Nominating Committee.

Mr. Chairman, the Nominating Committee makes that recommendation, and I move you, sir, its adoption.

PRESIDENT REECE: You have heard the recommendation from the Chairman of the Nominating Committee and his suggestion. Is there further discussion.

DR. J. H. SHUFFORD: I am a member of the Nominating Committee too, and it is my thought, further along with what Hubert has stated, that a negative report should be required from each county or each district, so that you would know that they had no nominees or preferences.

DR. SAMS: I second the motion of Dr. Poteat.

DR. PASCHAL: As I understand it, this report is to reflect the sentiments of the different county societies and not just the attitudes of the councilors themselves.

PRESIDENT REECE: As I understand it, the councilor is to contact each county society in his district and ascertain from

them if they have any wishes, positive or negative.

DR. KOONCE: I would like to make a substitute motion that the Council go on record as considering that to be a prerogative of the Nominating Committee to request the help of the councilors. It has the same effect and doesn't make a hide-bound rule.

[The substitute motion was duly seconded by Dr. Paschal.]

PRESIDENT REECE: We will vote on the substitute motion first then. All in favor of the substitute motion? Opposed? The substitute motion is carried.

DR. POTEAT: I was under the impression that I had reported to Mr. Barnes and I here report that the Nominating Committee decided, or recommended, that the 1961 meeting be in Asheville, 1962 in Raleigh, and 1963 in Asheville.

PRESIDENT REECE: Report of the Committee on Constitution and By-Laws.

MR. BARNES: Mr. Chairman, Dr. McMillan has not had a meeting since January, and he sent me some material and asked me to whip it into shape for his report, which I have done, and then he called me two or three days ago and said that he would not be able to get to Raleigh until tomorrow night, and that he was going to hold a meeting of his Committee tomorrow night at nine o'clock.

PRESIDENT REECE: May I suggest since we have all been supplied with copies of this that some of us look it over between now and tomorrow and take it up then.

MR. BARNES: I think about half of it is ratifying amendments that you undertook last year in the House of Delegates, and then there are some few additional amendments to be reported for consideration.

PRESIDENT REECE: Then we can determine whether it will be necessary for us to have a special session to hear Dr. McMillan and his report.

DR. BEDDINGFIELD: Item 12 on there looks like it might be a controversial thing. That's on page five.

MR. BARNES: Apparently, the Lenoir-Jones-Greene Counties Component Medical Society has proposed in a resolution that the Constitution be amended in respect to Article VIII, Section 2.

DR. A. JOHNSON: Do you want a motion on that?

PRESIDENT REECE: Yes, sir.

DR. A. JOHNSON: I think we should make a motion that the Executive Council recommends to the Committee on Constitution and By-Laws that they delete that por-

tion of the Constitution which gives unquestioned voting powers to the Vice Councilors, and that the problem of the Vice Councilor vote be taken care of as it is currently set out in the By-Laws.

It is set up in the By-Laws exactly as it should be. Just delete that portion referring to Vice Councilors in the Constitution.

PRESIDENT REECE: You have heard Dr. Johnson's motion. Is there a second?

[The motion was duly seconded by Dr. Koonce, put to a voted and carried.]

DR. KOONCE: May I make a suggestion that since Dr. McMillan isn't going to be here, that the report of the Constitution and By-Laws Committee be referred to the House of Delegates.

PRESIDENT REECE: Section 10 on Page 4.

MR. BARNES: In this report of the Committee on Constitution and By-Laws, a problem has been raised with reference to the functioning of the Committee on Grievances. They have a recommendation here, Amend Chapter X, Section 9, Subsection "w" by striking out the second sentence of this sub-paragraph and inserting in lieu thereof the following:

All statements made to or testimony given by a member of the Society who has been invited to appear before the Grievance Committee or the Executive Council of the Society shall also be considered privileged communications and shall not render such persons or witness liable to any member of the Society. Or insert the following in lieu of the second sentence:

All statements made to or testimony given by any person who has been invited to appear before the Grievance Committee or the Executive Council of the Society shall also be considered privileged communications and shall not render such person or witness liable to any member of the Society.

DR. KOONCE: Wasn't that discussed in Pinehurst at that last meeting and approved by the Executive Council?

PRESIDENT REECE: It was discussed.

MR. BARNES: In the discussion in January, at the end of the discussion, Dr. Baker says, "As I understand it, we ought to either approve the principle that we are talking about, or disapprove the principle. If we approve it, then we should ask our Committee on Constitution and By-Laws to work it out and word it so that it can be clear. I move we approve the principle of this and ask the Constitution and By-Laws Committee to work out the wording of it."

"That is the intention of my motion," Dr.

Sams says, and Dr. Baker says "I second that motion then." Dr. Reece says, "Is there any further discussion?" The motion was put to a vote and carried.

So it is in the lap of the Constitution and By-Laws Committee, and this is their effort to get language which they can consider tomorrow night and bring to the House of Delegates.

DR. KOONCE: I see. The present By-Laws reads "any person," and he changes it to "a member of the Society." That's right. I agree with that.

MR. ANDERSON:

It is a policy question as to whether you want to extend it to only members invited, or all persons invited.

PRESIDENT REECE: Do you wish to tell this body the importance of this policy question? We may not all realize the significance of it.

DR. BONNER: What is the advantage in changing it?

MR. ANDERSON: Dr. Baker's argument on it was that he did not want to consent for anyone to come before the Grievance Committee or to write in and with immunity make any complaint they wished about him, or concerning his conduct or practice, and he disapproved of that immunity being given.

Now the immunity was given as part of the setup of the Grievance Committee. When it came before the By-Laws Committee, the Committee realizing that it involved a very serious policy decision which affects the Society and the operations of the Grievance Committee, very properly referred it to the Council for decision.

PRESIDENT REECE: We are charged with the responsibility of setting a policy here concerning the action of the Grievance Committee. Is there any further discussion?

Any recommendations you wish to make as to the wording, that we are to instruct the Committee on Constitution and By-Laws to bring back here?

DR. KOONCE: I make a motion that it be left as it is.

DR. A. JOHNSON: Does that take care of everything as it now is?

DR. KOONCE: It was the original intent of the Grievance Committee when it was organized that everybody be given immunity.

DR. A. JOHNSON: I second your motion.

PRESIDENT REECE: You have heard the motion made and seconded that it be left as it is and not changed. All in favor say "aye"; opposed? It's carried.

Are there any other items in this that we should take up concerning policy?

DR. BEDDINGFIELD: They are asking

for our opinion, apparently, on the change in making staggered terms on the Executive Council. I think we ought to approve or disapprove.

DR. BONNER: We have a Nominating Committee that nominates the Council. He doesn't necessarily have to renominate the same fellow.

I would like to make a motion that the Constitution and By-Laws Committee leave that thing like it is and not keep changing everything.

[The motion was duly seconded by Dr. Williams.]

PRESIDENT REECE: The motion has been made and seconded that we leave this as it is. Any further discussion? All in favor say "aye"; opposed "no." It's carried.

I am going to make this decision now, since many of us have not had time to go over this completely, that we let the action stand on this so far, and during the evening and sometime between now and tomorrow that we look this over and tomorrow we will reconsider this report.

I think there are several things in here that we would all like to spend a little time on, and it is too detailed, since the Committee has not had time to go into it. That will be an item of discussion in the Executive Council tomorrow, to review this whole report, and we will have further discussion on it tomorrow, in case you want to look at that again.

Report of the Treasurer, Jim Barnes.

MR. BARNES: I have the audit report, President Reece, and that has been sent to every delegate and alternate members of the Council. I might say the summary shows that there was a total of \$221,019.67 income during the year 1959, and expenses of \$184,362.07, leaving an excess of income over expenses of \$36,657.60, less capital expenditures, which leaves a net operation income of \$33,866.33.

Now you started out the year with a budget provision of \$188,550 estimated, and came in with \$221,019, which is \$32,469.67 over what you had estimated, and you had authorized expenditures of \$193,215, and we actually only spent \$184,306.07. So the combination of excess income and lower expenditures than authorized resulted in this net operating income.

Dr. Benton is here, and I think he has followed this pretty closely, as Chairman of the Committee on Finance. He may want to comment on this.

PRESIDENT REECE: Dr. Benton, you are recognized.

DR. BENTON: I have no further point to make, unless there are some questions. We are solvent.

PRESIDENT REECE: You have heard the report. What is your recommendation? Do you have a motion that it be received?

DR. NORFLEET: I move that it be received.

[The motion was duly seconded.]

PRESIDENT REECE: We have heard the discussion, the recommendation and second that this report be accepted. All in favor say "aye"; opposed "no." It is so carried.

Dr. Rousseau, we will now recognize you for the National Legislative Action Report.

DR. ROUSSEAU: I have very little to report that you gentlemen are not already familiar with. I think you gentlemen have noted that House Committee voted 17 to 8 against the Forand Bill, but the most alarming news we have about national legislation is that AFL-CIO President Meany says it is a must on his list for this session of Congress, and they are going all out to still get the Forand Bill passed.

You are familiar with the Administration bill which has just been proposed in the last few days, which is for the government and the states to share the expense of insurance for the over 65 age group, hospital insurance, and provide some other benefits in addition to that. This is going to cost something like 1.2 billion. Where is the money coming from? It means the states have got to put up all that money.

One thought I have about it is that the medical profession gave away over 5 billion dollars in free medical services last year. If the Federal Government and the states take it over, are we going to continue to give that, and who is going to pay for it? I don't think a lot of us are going to be willing to continue to give that amount of free medical service, because I am not satisfied with the Administration's bill; I think it will be a foot in the door, and of course you know it will be full of amendments each election year until it is a fully socialized medical bill.

That has been the history of these things in every country that has socialized medicine, and I think most of you—I know very little except what I see in the papers and the last few days, and I am sure most of you have seen the same thing.

The AMA has been very silent since the President's proposal came out. I haven't heard anything from them, have you?

PRESIDENT REECE: Mr. Nelson is going to tell us about this.

DR. ROUSSEAU: I am glad he is here, because I hadn't heard a word from the AMA since the Administration's proposal. Gentlemen, we haven't won the battle by any means, and I sometimes seriously

question whether we will win the battle, but we can't give up. We have got to keep fighting for our freedom. Thank you, Mr. Chairman.

DR. POTEAT: I would like to bring one matter very briefly to this Council. I have written Dr. Rousseau and Dr. Westbrook Murphy about it. I had the misfortune, or fortune, a week ago to have dinner with a very prominent member of our profession from Ohio. To make a long story short, it is his opinion that all doctors should be on a salary, that the Federal Government and the state governments, and the local hospital administrators should be in charge of all medical services; that it is perfectly ridiculous for us to oppose a thing like the Forand Bill; that we may as well accept it because it is inevitable; that we are going to have this rammed down our throats and we may as well do it ourselves.

He told me that instead of my objecting to these things—and I gave him quite an argument for a couple of hours—that I ought to be the one to take the lead in North Carolina to help stimulate this thing; that Mr. Walter Reuther is perhaps the finest administrator in this country, and he would be a fine man to help run this deal. I asked him if Mr. Jimmy Hoffa could be his assistant.

Gentlemen, I don't mind calling his name. It's George Grile, Jr. of Cleveland Clinic. It just shook me right off my feet.

PRESIDENT REECE: I heard the repercussions of that all the way down in North Carolina, in Wilmington, this week. Some of your cohorts told us about it.

DR. W. JOHNSON: Sam Rayburn's brother had an operation for cancer and died, and it cost several thousand dollars, and Rayburn said he had to pick up the bill, and pay it, and he was able to do it, and glad to do it; but a lot of other people could not have done it, and that sort of crystallized his sentiment that we must do something for poor people who cannot pay.

PRESIDENT REECE: We have Mr. Richard Nelson of the AMA with us. Mr. Nelson, do you have any comments at this time?

MR. RICHARD NELSON: Dr. Reece, would you want to read Dr. Orr's statement to the group? They are short pages.

MR. BARNES: This is a telegram dated the 6th of May, for immediate release, from Chicago:

Dr. Louis M. Orr, Orlando, Florida, President of the American Medical Association, issued the following statement today on the Eisenhower Administration's medical care plan for the aged which was announced in Washington

yesterday. Dr. Orr's complete statement in behalf of the AMA follows:

The Administration proposal is based on the false premise that almost all persons over 65 need health care and cannot afford it. This is not a fact. The truth is that a majority of our older people are capable of continuing a happy, healthy, and in many cases productive life. Of the more than 15 million persons in the nation over 65 years of age, only 15 per cent are on old age assistance. An undetermined number, although able to finance other costs, find it difficult to withstand the additional burden of the cost of illness.

It is for these people that something should be done. Neither the Forand advocates nor the Administration proposal are tailored to meet these problems.

Here is AMA's positive 8-point program for the health care of the aged:

(1) The needy aged. These aged now receive health care through OAA programs. Here the need is for better organized medical care programs including improved preventive medical care.

(2) The near-needy. This is the group whose size is indeterminate, who can meet ordinary costs of living, but cannot pay for health care costs. The AMA supports a state-administered program of Federal grants-in-aid to the states for the liberalization of existing OAA program so that the near-needy could be given health care without having to meet the present rigid requirements for indigency. A liberalized definition as determined locally would permit an expanded program and encompass the near-needy group.

(3) Facilities. Better nursing home facilities for the long-term care of the aged person, especially those over the age of 75, are the most urgent health care need before the nation today. The average age of nursing home patients is 80, and their average duration of stay is 2 years. It is here that major improvement can be brought about. AMA supports Federal programs for the provision of grants through the Hill-Burton mechanism to provide for new nursing home additions to existing hospitals. For proprietary nursing homes, the AMA supported the recently enacted amendment to the Federal Housing Act providing for government guaranteed mortgage loans to proprietary nursing homes. AMA is also co-operating with the American Nursing Home Association and the American Hospital Association in an effort to bring about a rapid improvement in medical

care provided in nursing homes.

(4) Voluntary health insurance. Health insurance and prepayment policies tailored to meet the needs of the aged for long-term nursing home care must be developed as rapidly as possible. Health insurers and the Blue Cross and Blue Shield plans across the nation are already experimenting in this new area of coverage.

(5) Home nursing care. Care of the aged patient at home is psychologically, medically and financially desirable. Many programs to promote home nursing care are being developed.

Homemaker's services also provide opportunities for children caring for aged mothers or fathers to continue gainful occupation. They need to be expanded.

(6) Attitude toward aged. A basic change in attitude toward the aged person must be brought about. The person who reaches 65 has not suddenly become nonproductive, and senescent. On the contrary, most persons over 65 are reasonably well and able to work. Increased productivity by eliminating compulsory retirement and permitting voluntary change of work is an essential part of the answer to the present problem.

(7) Health education. Many older persons are unaware of the need for continuing healthful nutrition and other practices that contribute to good health. And the "will to live" is essential to continuing health. Preventive medical measures instituted long before the age of 65 also can contribute materially to the promotion of good health after age 65.

(8) The purchasing power of the dollar. One of the principal economic problems of the aged person in the last twenty years has been the constant and continuing erosion of the purchasing power of his pension benefits. Any government program to help the aged must be anti-inflationary and maintain the purchasing power of fixed pension and annuity benefits.

Sensible economical health care programs for the aged that preserve freedom at the same time that they promote security must necessarily be limited to support for the needy aged and leave to voluntary, competitive, private enterprise, those activities needed to improve the health care of the rest.

PRESIDENT REECE: Mr. Nelson, do you have anything you would like to add to this?

MR. NELSON: I would just like to take a minute to discuss a couple of items with you with reference to this.

First I want to express to all of you folks here our appreciation in AMA for the very fine cooperation and action that you have carried out in response to each of the many requests that we have made upon you during particularly this session of Congress. As you know, this Forand concept, or the health care of the aged, has now become our greatest domestic issue in this country. This maneuvering in this particular session of Congress is as complex as any that has been experienced on any legislative issue for a number of years, so it has been a trying and complicated sort of thing.

We are certainly hopeful for your continued activity on a wholehearted basis.

I might comment to you that you have received a considerable amount of publicity and credit for one of the activities that you established, and that was the emergency telephone conference that you set up sometime back, and I want to pass that word back to you.

We continue in AMA to be in a position of not specifying specific legislation, and I think that this is appropriate because anything that is proposed at the present time will go into the grinder and come out as hash on the other end, and we feel that it is not a good idea to get a constructive proposal ground out in this kind of way.

However, the confusion that exists in Washington today does give us a position of strength and as long as we maintain our steadfast determination that we shall not have foisted upon us some inappropriate piece of legislation, we are in a relatively strong position because with these people all arguing about what kind of a program they want to promise their voters back home, out of this confusion it is going to be difficult for them to get a unified program and stability. Certainly the Democratic Congress is not going to accept with any grace an Administration proposal. The President has made it quite clear that he will not accept any Social Security based program.

It seems to me in this area there are two or three criteria we need to keep in mind. One is that the patient, the individual, is the person who is most important in this thing, and it is the care of that individual on a generous basis, where there is need to any degree, that is important; and; secondly, that we need to maintain that we have the kind of program with local administration that allows to provide the care and the provisions which are needed in the individual case and not determined by a federal bureaucracy on a slide-rule basis in Washington, that we don't provide care on that basis, but that we provide it on the basis

of what the individual happens to need, so that we can effect a maximum treatment of that individual; and; thirdly, it seems to me that it is important that we keep in mind that there must be some mechanism which prevents malingering and abuse of the program. Somehow there has to be a conscience involved, and so far we have only been able to demonstrate the use of such a conscience when we have local administration. When we take our money and send it to Washington, nobody seems to have any conscience about how it is used or where it is used, and so it is important that we keep that in mind.

I think if we keep these principles in mind, it may be that we can come out with legislation in which some sort of appropriate federal function is developed, that it is not developed to the disadvantage of the patient, to the medical profession, to the taxpayers, or to anybody else that is involved.

PRESIDENT REECE: Thank you, Mr. Nelson. Any further comments?

DR. ROUSSEAU: Mr. Chairman, I appreciate Mr. Nelson's comments. He has certainly been a great help to us. Mr. Barnes mentioned in a brief note to me the other day a resolution you might want to read. Jim, do you have it?

MR. BARNES: I have a resolution that the Florida State Medical Association enacted at their session on the 8th day of April. I think that this was an exemplary movement on the part of the Florida Medical Association, and since we were meeting, we might well, through this Council, have a committee designated to draw a resolution to bring to our House of Delegates and give expression of our own to the same point and subject. I have that specimen here, so that if the Council took an action designating a committee to draft a suitable resolution on the subject—

DR. SAMS: I suggest you read it.

MR. BARNES:

Whereas, the Congress of the United States has for several sessions through the Ways and Means Committee of its House of Representatives, considered H.R. 4700 (the so-called Forand Bill), and

Whereas, The Ways and Means Committee has more recently, in this 86th Congress, spent long and arduous hours listening to testimony in a democratic fashion from individuals and organizations interested in the problems of the aging, and

Whereas, The physicians of the nation, together with many other lay organizations and individuals, feel that the above

legislation is "socialized medicine" for a segment of our population, with an ever-increasing cost to all citizens, and

Whereas, These groups and individuals feel that political medicine would hinder rather than help the aging population healthwise, and

Whereas, It is the desire of this Association and physicians everywhere to better the health care of this group as well as that of all Americans, and

Whereas, It is felt that such programs can best be obtained and maintained through a voluntary system which would not destroy the valuable doctor-patient relationship, and

Whereas, The members of the medical profession, along with other groups, are continuing to explore and study methods for better health care of the aging and all other citizens, and

Whereas, the House Ways and Means Committee by majority vote of 17-8 on March 29, 1960, did disapprove the Forand Bill, and

Whereas, The Administration and individual members of Congress have expressed opposition to same, now therefore be it

RESOLVED, That this House of Delegates of the Florida Medical Association, meeting in annual session in Jacksonville, Florida, the 8th day of April, 1960, go on record as commending those members of the House Ways and Means Committee, the Administration and others who so forthrightly spoke out in opposition to H.R. 4700, and be it further

RESOLVED, That the Florida Medical Association express its admiration, appreciation and commendation to the above groups and individuals for their courage, their interest and their foresight in behalf of all people concerned with this problem, and be it further

RESOLVED, That a copy of this Resolution be sent to the President of the United States, to the Vice President of the United States, to the Speaker of the House of Representatives, to the members of the House Ways and Means Committee, to the Secretary of Health, Education and Welfare, to the Honorable members of the Florida Congressional Delegation, to the Board of Trustees of the American Medical Association, and to all state medical associations.

PRESIDENT REECE: You have heard the discussion concerning this resolution. Is there a recommendation that we should ask the House of Delegates to take the same type of action?

DR. AMOS JOHNSON: I would make a motion that this Florida resolution be submitted to our Legislative Committee and that they produce a resolution appropriate to this proposition to be introduced before our House of Delegates at one of its sessions.

[The motion was duly seconded by Dr. Sams.]

PRESIDENT REECE: As his Chairman of that Committee, I will appoint Dr. Hubert Poteat to do it, and if you cannot find the members of your committee to help you, you can select any of your friends from this group.

[The motion was put to a vote and carried.]

PRESIDENT REECE: Hubert, we have confidence in you. You can act for your Committee.

Section (i), Report of Committee on Negotiations.

MR. BARNES: Mr. Chairman, under the Constitution and By-Laws, the members of the Committee on Negotiation are named by the President, and are required to be confirmed by action of the Executive Council. Now Dr. Amos Johnson resigned as a member of this Committee sometime this spring, and you designated Dr. Hubert Poteat to succeed him on that Committee. It is a question of this Council ratifying your action in naming Dr. Poteat to the Committee on Negotiations, serving out Dr. Johnson's term, which will be 1965.

DR. SAMS: I move we confirm the appointment of the President.

[The motion was duly seconded, put to a vote and carried.]

PRESIDENT REECE: Auto Crash Injury, Research Report.

MR. BARNES: As is customary, the doctors in North Carolina in certain named areas of the state have, during the year, cooperated with the State Board of Health and the North Carolina Highway Patrol, and the Cornell Medical School, which is conducting a survey on auto accident injuries in the state, and we have ordinarily requested of them a report to be submitted to this Council, and through this Council to the House of Delegates.

So we have a long report here which no one has had time to digest, but we do have a letter which goes on to enumerate the cooperation which the physician members of the State Society have lent to this continuing survey in North Carolina, and I think that all that is necessary is for you to receive this report as information, and then perhaps later on let us get the thing produced in quantity for distribution and send it to the County Medical Societies for information.

PRESIDENT REECE: Is there a motion that we accept this as information and it be condensed and submitted to the various societies for distribution?

[Such motion was regularly made, duly seconded, put to a vote and carried.]

We go now to Section 7, District Councilors' reports. Do we have anything new?

[Upon calling all numbered districts, none had anything additional to report.]

PRESIDENT REECE: Do I hear a motion that we adopt the reports as submitted in the compilation?

[It was so voted on motion regularly made and duly seconded.]

Item 8, Annual Report of Commissioners, Administration Commission.

MR. BARNES: Dr. Rainey is not here.

PRESIDENT REECE: Dr. Benton, do you have anything you would like to report for the committees—Finance and Medical Society Facility?

DR. BENTON: The Headquarters Committee—we do recommend that the function of the Headquarters Committee be placed under the Finance Committee. The reason for that is that at the present time, with the additional place that we have at headquarters, we have adequate space for the foreseeable future, and there will be no need to consider a new building right away. There still needs to be a committee for Jim to turn to when the question of housing comes up, and the Finance Committee has to make the allotment of the funds anyway, and we thought it would be a little bit more effective if the duties of that committee were assigned to the Finance Committee.

DR. AMOS JOHNSON: Would you soon see that whole committee deleted?

DR. BENTON: I think we need an advisory committee. Jim, for instance, if he wants another room down there, needs to go to somebody.

DR. A. JOHNSON: Would not the nucleus of ten selected from the old committee to be authorized in an advisory capacity—they would not have any functions except when they were activated by the Finance Committee. That was what I was going to propose. Is that within my prerogative?

MR. BARNES: You see it is not a standing committee.

DR. A. JOHNSON: Then it is taken care of.

DR. BENTON: Will you tell us whether our investments last year made any money or not?

MR. BARNES: There was some interpretation in correspondence with Dr. Claude Squires, and you sent me a transcription of that. On our investment of \$50,000, which

we made last October, by liquidating the Government bonds, we got some 4,677 shares of Investors Mutual Stock. There was some allegation that we had lost some six or seven thousand of that investment. Actually, it was understood by this Council that there would be a loading charge of some \$4,000 for the purchase transaction, and that, of course, was on account of the fact that you didn't get but 4,677 shares of stock. That has increased by two dividends of 420 some odd shares twice since October, so that we have now, roughly, 54,000 shares of this Investors Mutual Stock.

As of September 30th, the report here shows that the assessed value of the shares was \$10.18. Now as of March 31, 1960, the net assessed value of these shares was \$10.11. In other words, they had dropped by seven cents in that period of time.

Now if you multiply it times the shares, we have lost about \$387 in investments, but we have gained about \$800 in dividends, so we wouldn't have any net loss. We would have a net gain of about \$500.

DR. BENTON: There is one other committee that is an ad hoc committee to the Finance Committee, and that is Jesse Caldwell's committee to work on the Jenkins-Keogh Bill. He wants to make a report to the House of Delegates, and that Committee has been functioning, and he has got a preliminary draft of a proposal for the North Carolina Medical Retirement Savings Plan. Would you like to hear that now?

The only thing he asked you now was to continue this committee. We know the Jenkins-Keogh Bill has not been passed as yet, and the committee has done about as much as they can do until it is passed. I don't know whether you want me to read this or not.

PRESIDENT REECE: I think not.

DR. BENTON: That's all I have to report.

Jesse Caldwell asked me to ask you to continue this committee.

PRESIDENT REECE: You have heard the request that this committee be continued.

DR. BONNER: I move that it be continued as an ad hoc committee.

[The motion was duly seconded, put to a vote and carried.]

DR. SQUIRES: Mr. President, that request came from Jesse Caldwell, and I would like to have Mr. Barnes write him and inform him.

MR. BARNES: We will do that.

DR. BENTON: He will be down here. I will talk to him.

PRESIDENT REECE: Dr. Shufford, your

Commission is next, Advisory and Study Commission.

DR. SHUFORD: If you will look at Page 24 in your compilation, we will go through these various committees. There are eight committees under this Commission.

The first is Dr. Roscoe McMillan's Committee, the Committee to the Auxiliary and Archives of Medical Society History. I don't believe there is anything of particular importance there, except in Item (b), the Auxiliary plans to set up a Mental Health Endowment similar to the Tuberculosis Bed Endowment. I understand that they have paid up their Tuberculosis Bed Endowment, and now they are going into this Mental Health Endowment on the same basis as they were on tuberculosis.

The objectives are to be training of medical and allied personnel, research and improvement of patient care. I believe that it is the only item in that committee report of any great significance.

The Committee on the American Medical Education Foundation, Dr. Ralph Garrison is the Chairman of that. Dr. Garrison, do you wish to make any comment at this time?

DR. GARRISON: The only thing is that in addition on Page 44 of the report, where the contributions last year were \$4,255 in the state, and this year when this report was made, they were \$5,995.84; but since the time I wrote this report there has been an addition of \$2,200 made, which makes the approximate amount this year \$8,195.84, which is a gain of \$3,940, which is a pretty substantial gain over last year, but still is quite disappointing when we realize that the big majority of that has come from the members of the Auxiliary.

I think still that even with you carrying the information in the Blue Cross or Blue Shield letter, and publicizing it through public relations—I still feel the reason the North Carolina doctors don't contribute more to the medical schools through AMEF is the fact that they don't yet understand the money contributed through AMEF can be earmarked for their local schools, and the over-all amount given through AMEF does not affect the amount of money that the local school gets from AMEF.

In other words, last year we got about \$22,000 for the medical schools in the state, and yet we contributed in the neighborhood of \$8,000, whereas in South Carolina last year, there were 223 contributors, and the amount was \$68,634 to AMEF. Most of that was earmarked for the school and sent direct to the school, but still it showed up in the AMEF figure, and did not affect the

amount that was allocated to each school.

DR. SHUFORD: Both Dr. Garrison and myself feel—and I made this recommendation, if you will notice, and I couched it so that nobody would be on the spot—that consideration of raising medical society dues earmarked for AMEF be given by the proper authority. That is neither here nor there. I think that should be considered.

Now we come to the special report of mine, the Blue Shield. Our participation by the doctors remains practically static; it is between 52 and 53 per cent. We are also making some efforts now to effect Medical service—those of you who are familiar with our medical rider, it eliminates the first two days of care, and we are trying to work out a program which will pay for the first two days of care, that is the professional fee to the physician, particularly in certain serious type illnesses which would involve primarily internists, where internists would in all probability receive those referred patients.

We did take action that I want the Executive Council to criticize, delete, or obviate, or approve. In the past, the Blue Shield Committee has not allowed Hospital Saving Association to release the name or names of any participating physician to anyone. We felt that some of the accounts we might sell on the Doctors' Program, they asked for that information—well, who participates in this community? We felt that perhaps that was unfair to the people who were interested in who participated and who didn't participate.

This action was not taken with any sense of punitive or coercive type of intent. The committee unanimously voted to allow Hospital Saving Association to release lists of participating physicians to interested parties, feeling that such information would aid in the sale of the Doctors' Program. That may be subject to some criticism. It is a deviation from past practice.

There is no intent of passing lists out like you sell newspapers on the corner, but if someone, General Electric or Westinghouse, or somebody, says "We want to know before we purchase this Blue Cross-Blue Shield deal who are the participating physicians in this community," and we felt that the salesman for Hospital Saving would have a better talking point if he was allowed to secure that information for the prospective customer.

I would like some approval or disapproval.

PRESIDENT REECE: You have heard the action of the Committee. They have permitted that. They want to know whether we approve or disapprove.

DR. SAMS: I move we approve the action of the Committee.

[The motion was duly seconded.]

DR. NOFLEET: I believe before we do that there ought to be some information to every doctor in the state that is going to take place.

DR. SUFFORD: Certainly this has been considered. What I wanted to draw your attention to is that after a period of approximately seven years we still have approximately the same number of participating physicians as we did the day we started. If we are going to attempt to combat some of this federal intervention in medicine, we have got to do something more than standing still. That's what the action was, but I didn't want to do this without approval of someone.

DR. NORFEET: I am ready to vote under those circumstances.

PRESIDENT REECE: Is there any further discussion?

[The motion was put to a vote and carried.]

DR. SHUFFORD: On Page 25, of the Report you see there approximately 125,000 persons now covered under the Doctors' Program, and that is out of a total of about 600,000 subscribers to Hospital Saving Policies.

The Senior Certificate is now on sale; approximately 800 persons have availed themselves of this. The dental rider that has been developed is now available to the public, and it has been approved by the Insurance Commissioner.

I think each one of the doctors who were chiefs of staffs and administrators received a letter calling attention to an effort at local level to keep the needless hospitalization and prolonged hospitalization to as low a level as possible. There is an extended benefits endorsement which is purchasable now at one dollar individual and two dollar family, which can be added onto your present Blue Cross-Blue Shield benefits, and that contains out-patient benefits, 80 per cent of x-ray and things like that, and that is an effort to keep people out of the hospital for diagnostic purposes.

DR. THOMAS MURPHY: Is that available all over the state?

DR. SHUFFORD: Yes, sir. If you will look at the Blue Shield Committee report on Page 52, that is one of the exhibits. I think it is probably Exhibit 4, Extended Benefits. You can peruse that at your leisure. It is very informative.

We had set up with your consent so-called district subcommittees on Blue Shield in an effort to bring Blue Shield into the local County Societies and at the local level,

and that didn't prove very satisfactory because of difficulty in distances, and difficulty in arranging meetings and getting the subcommittees together, and we are now in the process of trying to secure one doctor in each county to act as a so-called Blue Shield consultant, and he will be provided with all the information and activities of the parent committee. This is not a committee; they are just consultants to the committee.

There will be an effort to bring it to the county society and let the consultant represent us—the Doctors' Program, not the Blue Shield Committee—at the local level. I don't think that requires any action. That is purely a matter of information in an effort to further the program.

Item (h), on May 5, 1958, at Asheville, Hospital Care was endorsed and approved by the House of Delegates to be allowed to sell and administer the Doctors' Program under exactly the same conditions as Hospital Saving.

In that action of the House of Delegates there was no specific statement as to Blue Shield. As I understand it at the moment, Hospital Care is authorized and is still authorized to sell the Doctors' Program because they have now changed their board structure to follow the requirements of the State Medical Society, and the Executive Council on the 31st of January 1960 in Pinehurst approved them as having become qualified, altered their board structure, and so we immediately again attempted to integrate Hospital Care into our Blue Shield program. Hospital Care then immediately began to make efforts for recognition on a national level.

Before you can get the Blue Shield emblem, you have to be approved by the National Blue Shield Plan; so actually we don't approve them for Blue Shield. We approve them as qualified to apply, and this information now is not in this report.

They went out to Los Angeles and met with the committee that controls this application and approval, and they were neither approved nor disapproved. They were more or less put off, so Hospital Care has not been recognized by National Blue Shield as a Blue Shield agency at the present moment. However, under action of the House of Delegates and the Executive Council of the State Society, they are still qualified to sell the Doctors' Program and administer it if their intent was what they meant.

The only recommendation is continued efforts to further the doctor's program, and I assure you as long as I am connected with it, we will do it.

Committee on Medical Credit Bureau, nothing new. Committee to work with Industrial Commission of North Carolina, Item (a), base fee for hospital calls after second visit from \$2.50 to \$3, I thought most of us would be interested in that change.

Committee on Medical Care of Dependents of members of the Armed Forces, Dr. Cogdell, nothing particularly new on that, except that the original medical care program was restored effective January 1, 1960. There have been some benefits taken away, as far as out-patients are concerned.

Committee on Students, AMA Student Chapter, North Carolina, John P. Davis, Chairman, approximately the same report as last year. The Student Section, Dr. Reece to welcome, we provided the transportation and pay for one delegate from each of these AMA Student Chapters to attend the National Student AMA in Los Angeles, California. Thank you.

DR. AMOS JOHNSON: May I say one thing, and I hope it doesn't precipitate a discussion. In discussing the policies that we are selling on the senior citizen certificates, I question whether we are accomplishing as much in selling that policy, or whether those who buy that policy have bought as much if they have some preexisting condition. In talking to a lot of people who have given thought to our senior citizens, the majority of them are going to be hospitalized and die with their preexisting conditions that they arrive at 65 or older with, so I don't know just how much we have accomplished in selling these things that we are being so proud of.

PRESIDENT REECE: You have heard the report of Dr. Shuford's Commission. What is your pleasure?

DR. SAMS: I move we accept the report. [The motion was duly seconded by Dr. Squires, put to a vote and carried.]

We will recess now until nine-thirty in the morning.

[The meeting recessed at five-fifteen o'clock.]

SUNDAY MORNING SESSION

May 8, 1960

The Executive Council reconvened at nine forty-five o'clock, President Reece presiding.

PRESIDENT REECE: The Executive Council will reconvene.

Going back to Page 1 of your agenda, under Section 4, letter from Stanly County member, the Committee on Hospital Professional Relations report was approved by this Council, as it related to the problem that

originated in Stanly County concerning a physician that came there and the action that the Board of Trustees of the Stanly County Hospital took in placing this man on the staff by action of the Board of Trustees above the recommendation of the staff.

I think that is a long, detailed discussion that most of us are familiar with, and Dr. Mees's report covers that. Fortunately, that man left North Carolina and that problem was more or less solved. But still Dr. Mees's committee supported the staff of the hospital and pointed out that it is the prerogative and the right that the professional staff of a hospital should determine the qualifications of the men that go on the staff of that hospital, and that the Board of Trustees of a hospital should have in good faith respected their principles and appoint or refuse to appoint as the staff would recommend.

We took action approving Dr. Mees's Committee, and it was reported in our Council that we were to send a copy of our action to the Board of Trustees of the hospital. This was not done for some time, until the transcription was back, and through some communication with them I told Mr. Barnes to withhold that for a little while, also in the light that Dr. Squires as Councilor had had some communications with an conferences with Dr. James Tuttle, the man that was involved in some of this reaction.

But I think the time has come where it is proper that we go ahead and send this letter to let the Board of Trustees at Stanly County Hospital know that we supported both their staff and our Medical Society Committee in approving or disapproving this man, and reiterating our position that the medical staff should determine the qualifications of the men that are to practice medicine.

Now Dr. Bivens is here. He is a member of the Stanly County Medical Society and the Vice Councilor for the district. There may be some comments that he would like to make concerning that. Dr. Squires is also familiar with this.

Dr. Bivens, do you have something to say on this?

DR. BIVENS: Gentlemen, I believe that this is a matter of principle; this is something that the medical profession will have to stand or fall on. We are not too concerned about the doctor who come in disapproved by our Credentials Committee, disapproved by the staff, disapproved by the County Medical Society, then put on our staff by the Board of Trustees and administrator.

We are concerned that your Executive Council has 18 pages of minutes out of your 208 pages of minutes of your January meet-

ing approving what we did, approving what Dr. Theodore Mees' Committee did, and they did a wonderful job; and yet our Stanly County Medical Society has had no word of it, except what we read in the *North Carolina Medical Journal* last month, thanks to Dr. Wingate Johnson, which stated that our actions had been approved, and Mees' Committee actions had been approved.

The Board of Trustees of our hospital, and the administrator, have had no information from your group, or the State Medical Society, stating that their actions were disapproved, and our Medical Society's actions and staff actions were approved.

Since that time when they put a man on the staff over our heads, they have not let up; they have continued to push, and they will continue to push. If it happens in any of the other larger towns, the fire will get bigger and bigger. I am certain that the hospital administrators over North Carolina know what they got away with down in Albemarle in Stanly County. I am convinced that this is a medical principle that we will have to stand on; something definite will have to be done, and we need your support.

PRESIDENT REECE: I accept responsibility for not dispatching this to the hospital, because I felt that at the time it was a little ill chosen that we send it. But I do think it is proper now that our actions that we took in January (1960) should be conveyed to the Board of Trustees at the hospital.

DR. BAKER: Mr. Chairman, is it clear in your mind that our actions in January were to the effect that you were to report our findings and actions to the staff of that hospital and send carbon copies to board members?

PRESIDENT REECE: Yes.

DR. BIVENS: May I make one further statement? Our Board of Trustees, probably as many of yours, is controlled by a few men. There are seven members on the committee, and believe it or not, three of them didn't know what was going on with the Mees Committee. The information was rather closely held; they didn't know what was going on while the Mees Committee was even there to make an investigation. There are 37 members of our Board of Trustees, which is an incorporated hospital, non profit, one of the first Hill-Burton hospitals, and I am certain they don't know what is going on.

It would be a great help to us if the resolution as put in the minutes in January was carried out so that every member of the Board of Trustees of that hospital received a notice from you.

DR. PASCHAL: I think it would be well for us in this group to advise the North Carolina Hospital Association of our stand in this thing, to advise also the American Hospital Association, the Duke Endowment Hospital Section, the Joint Commission on Accreditation, and in addition to that, let the American Medical Association know of our reaction to this particular problem.

I would make the motion that we advise these respective organizations of our action, of our attitude, and precede that by informing them as to what this brought to a head, and why we take this position.

[The motion was duly seconded by Dr. Sams.]

PRESIDENT REECE: Discussion?

[The motion was put to a vote and carried.]

PRESIDENT REECE: At this time, we will take up the special report from the national Blue Shield, and also report of the Board of Trustees from Hospital Care Association. I am going to let Dr. Hamilton present his discussion first. We have as our guest this morning Dr. Donald F. Stubbs from Washington, D. C. Dr. Stubbs is Chairman of the Board of Trustees of the national Blue Shield organization. Many of us have had contacts with him before.

An honor that has recently come to him is that on June 1st, Dr. Stubbs will receive the Health Award, U.S.A., from the Metropolitan Washington Board of Trade and the Chamber of Commerce organizations of the District of Columbia. This award was principally presented to him because of his outstanding work in the Blue Shield Medical Care Plan.

Dr. Stubbs, we welcome you to our organization this morning, to our council meeting, and we are glad that you can be here in North Carolina and help us expand our Blue Shield services to the patients and citizens of our state in every way.

Also with us this morning we have members of the Board of Trustees, that is professional members of the Board of Trustees, of both Hospital Care and Hospital Saving. They were invited particularly to be here, and we hope we can clarify this whole problem that we have. Dr. Jake Shuford of our Committee on Blue Shield is also here.

We are going to present this informally, but at this time, Dr. Hamilton, I would like to recognize you, and following that, Dr. Amos Johnson has some comments to make, and Dr. Stubbs then will take over.

DR. HAMILTON: Mr. President and members of the Council: I don't intend to review for you the long history of this

situation, but it is necessary that we say a little about what objectives we saw as your members on Hospital Care's Board of Directors with whom we went to Los Angeles to forward the petition of our organization for Blue Shield certification.

You will remember that in '58, this House of Delegates requested that we be allowed to sell the Doctors Service Plan on exactly the same basis as Hospital Saving. That required a change in the board structure of Hospital Care, which was finally implemented and effected, and on that basis Hospital Care requested approval of the national Blue Shield as a Blue Shield organization, and it was for that reason that three of your professional members went to Los Angeles.

We were very courteously received. They heard our plea. I think we made clear, as best we could, what your objectives were, which was essentially to extend the sale of the Doctors Plan, and what Hospital Care's objectives were, which was to be a Blue Shield organization, both indemnity and service.

They did defer decision on this matter on several bases, which I think Dr. Stubbs is in much better position to tell you than I.

We came home disappointed, but not defeated. They had given us several alternatives that we in North Carolina could undertake to obtain the same end, which he, I am sure, will tell you about.

I would like to say a word in terms of the attitude of the Medical Directors on Hospital Care. We were convinced in that meeting, in various sessions, that if there be some positive answer to federalization, as in the aged, for instance, it lies in Blue Shield, and we were very conscious there that North Carolina does not have adequate Blue Shield coverage in terms of the people.

We feel, and we feel strongly, that the Doctors' Plan could be extended in some considerable degree if Hospital Care were to sell it. We have been your representatives in the insistence that Hospital Care sell it under exactly the same circumstances and with the same control of the Blue Shield Committee as pertains in Hospital Saving.

There is a further element which you should be conversant with, and it was evident that national Blue Shield was—if two Blue Cross organizations are going to function in the state in the total territory, there should not be as a result of Medical Society's subsidy, in effect, a sales differential of such powerful impact as the denial of Blue Shield to one and the acceptance of Blue Shield in the other.

We are now entering in a period where Blue Shield is going to be of tremendous importance in terms of hospitalization and

professional coverage. *There can be no question that Blue Shield sooner or later is going to be our positive answer to the Government.* There can be no question at all that the people—and I am not talking about the doctors or the insurance companies—in this state, with the change in insurance that is coming about, should be able to have Blue Shield coverage without it being allied to one Blue Cross organization.

Thank you very much.

PRESIDENT REECE: Dr. Johnson!

DR. AMOS JOHNSON: Mr. Chairman, I would like to attempt to give this group some background of the whole situation and some posts that stand out in my mind when we begin to approach the subject of the solution of this problem.

I have been extremely interested in Blue Cross and Blue Shield in North Carolina since its inception. Some of you know that in our County, we even had a special program put on to sell the Doctors' Plan at one time, and at one time 11 per cent of all of the Doctors' Plan program that was sold in the State of North Carolina was held by people within the bounds of Sampson County, and adjacent small areas of additional counties. So it isn't just recently that I have been extremely interested in this proposition.

As I see it, there are about three, or maybe four alternatives that we have as a Society. One, we can wash our hands of it entirely and go home and not face the problem. That, I think, would be very bad.

Two, we can leave it as it is with the group in Chapel Hill (Hospital Saving) having it as a monopoly, as they have held it up to now.

Three, we can insist and reiterate our stand, add emphasis to it by having the House of Delegates, if they see fit, ask again that the national Blue Shield organization give accreditation to Hospital Care.

Four, we can organize from within the framework of our now existent Medical Society a third corporation which can and will, or would, administer our Blue Shield Plan for the State of North Carolina to the exclusion of the now existent Hospital Care and Hospital Saving Association, using them in the capacity of sales agent only, the plan to be administered from within the framework of the third corporation as to the fees, the programming, the policies and the payment for plans.

There are a few things that stand out in my mind that we should give thought to when we are considering this, and one is primarily that Blue Shield is concerned directly and only with professional services,

and that Blue Shield as it is now administered through our two agencies has on the board of these two agencies what, in effect, is a third party. We have a board of each of the two organizations which is composed of twelve men. Four are appointed by the Medical Society, four from the Hospital Administrators Association, and four from the subscriber public. Therefore, we have the board which is currently administering Blue Shield watered down with four men who are not directly concerned with the Blue Shield service benefits at all, and I am not at all sure that they are or should be on any board connected with Blue Shield alone.

Second, when we are thinking about our Doctors Plan—this is my concept of what is happening with it; I will say that this is entirely personal to me; that it is not being pushed to the extent that it could be and should be under the *present situation*, and I would be inclined to think that the reason in back of it might be that the Medical Society, those participating doctors, the 51 or 52 per cent that have signed up to participate, are underwriting the service benefits that are paid by this organization. I could be entirely mistaken.

It is my concept, and if I am wrong, I hope some of you will straighten me out on it right now: That the monies collected for the Doctors Plan service benefits, the payment to the doctors, is kept in a separate fund from the monies collected for the so called Blue Shield policies sold under other circumstances, that Hospital Saving and Hospital Care can and does take the monies collected from the sale of the indiscriminate indemnity policies and juggle them to any place they need to or want to within the financial structure of the organization. But they cannot do that with the money from the Doctors Service Plan. Therefore, if they pushed the Doctors Plan to its fullest, it would be in competition and to the detriment of some of the benefits derived from selling the other type plan.

Do any of you know if I am in error in that statement? We will assume that statement is correct then.

SECRETARY RHODES: Dr. Johnson, my only reaction to that would be that I have heard no open discussion of the fact that money from the Blue Shield plan is used indiscriminately in the general operation of the organization to which I happen to be the member of the Board. I don't know of that.

DR. AMOS JOHNSON: Let me speak one more minute to that then. As you know, I have been four times this past year to a

session of Hospital Saving Board, and I have had access to the financial reports, all of the financial reports of that organization for this year, and have seen them over the past years.

Am I incorrect in the statement that for this past year, and perhaps two or three years in the past, that the Blue Cross portion of Hospital Saving operated at a deficit?

SECRETARY RHODES: Right, that is correct.

DR. A. JOHNSON: And that monies were allocated or appropriated, or used, as a result of profits, if you want to call it that way, or excess of intake over outpay, for service plans, and the catastrophic plans, were put in to the hopper to take care of or, in effect, they did take care of the deficit created by the operating in the red of the Blue Cross plan. Is that correct?

SECRETARY RHODES: I think that is essentially correct. I believe the catastrophic feature was the one that was profitable, and that was not the service part.

DR. AMOS JOHNSON: You look back and you will see that both of them were profitable.

Ed Hedgpeth is back there. Would you want to correct me on that?

DR. HEDGPETH: The resources of the whole organization are back of any part of the program. That includes income from investments and everything else.

DR. A. JOHNSON: I am not indicting the organization. I think it is entirely within its rights in what it has done. Don't interpret what I am saying as an indictment against it. I am coming to the point right now that that portion of the money which is collected for policies to pay for medical service to the people, the subscribers, should be—and if a third corporation were organized should reflect itself if there be a profit either in (1) lower premiums to the people who are buying these Blue Shield policies, or (2) a higher rate of pay for services rendered; that that money is and should be allocated to medical services and should not be utilized for hospitalization, and that it should reflect itself in a lower rate of policy for Blue Shield, or a higher rate of payment for services rendered for the doctors of the State of North Carolina and if that were done under a third corporation setup it would be utilized that way, and there would not be the possibility of a tie-in for the utilization of funds from one type policy to another.

Then, to be said for organizing a third corporation in this state, a Blue Shield corporation in this state, would be some of the factors that we have spoken of already. One,

the elimination of the third party; (2) to stimulate the sale of the Doctors Plan—it would be in competition with no other plan at that time; (3) to prevent the juggling of funds and keep those funds that were exacted from the public for service benefits, keep them in service benefits; and (4) to reduce the premium of the Blue Shield plans, or the Doctors Plan as it had paid its own way, or to increase the payment for medical services rendered, or to take the profits from that and do what would be a much better maneuver.

The senior citizens certificate that we are selling now that excludes all pre-existing conditions, if it were combined into the Doctors Plan under this third corporation that we are talking about, along with the other Blue Shield plans, and they operated at a profit, we might then be able to take the senior certificate professional services plan and not exclude from it any pre-existing condition; so that we would then have a plan giving total care to these people, and it would then be an answer to the Forand Bill, and not just the sham that it now is. That would be the possibility that the others might be sufficiently profitable under the present setup to give proper care to our old age subscribers now.

We could certainly, if it were operated by the State Medical Society, I believe, get better participation from the doctors of the State of North Carolina. If it were their program and it were administered largely by them, or their representatives, I have a feeling that more of the doctors in the State of North Carolina would accept it.

And last but not least, and this may be far-fetched, and it may not be desirable—by creating a third corporation to add minimum Blue Shield, we would afford to our now two existing plans, Hospital Saving and Hospital Care, a place that they might, if it is advisable, some day consolidate. I can foresee that that would eliminate a lot of the difficulties that we have run into as a State Medical Society in our efforts to consolidate the two Blue Cross plans.

Now I am not advocating any of these. I am presenting that as it has possibilities, as I see them, and there may be other possibilities that some of the rest of you would like to present, or some of you would like to talk to these; but I did want to take this opportunity to give you the benefit of the thinking that I had had over the years on this proposition.

PRESIDENT REECE: Thank you, Dr. Johnson.

SECRETARY RHODES: Mr. President, I would like to speak to the one point that Dr. Johnson has made particularly, and that

is to this matter that he discussed regarding the formation of a separate corporation within the Medical Society, and the reason I speak is because I think with Dr. Sams, I am perhaps the oldest man on that committee, the only original member of that committee in this room that set up the Doctors Program.

We arrived one day in this hotel at the decision to do just that thing, and I should say there are several reasons why we changed our minds as a committee. The first one was that there was some general disagreement that the Medical Society ought to get in the insurance business. There also was the spectre of possible indictment by federal authorities for restraint of trade if we set up an insurance program of our own. And then there was this possibility, and somewhat of an indeterminate possibility of the cost of such an organization, and I would say here that certainly the administrative cost would be definite; and they at the present time, of course, as Dr. Johnson has said, are pooled in the operation of the agency that is selling the Doctors Plan. But those were mainly the objections to setting up such an organization.

Now we have learned certainly that in other areas such an operation does exist, and apparently exists successfully. For instance, in Pennsylvania, there is a single Blue Shield plan which is marketed by four of the five Blue Cross companies in the area of Pennsylvania.

So that I rise because I wanted to give you that background and explain to you why we didn't set up such an organization, why the committee decided against it, and secondly, to say that I think Dr. Johnson's plan has merit.

DR. BAKER: If we are going to take this profit and turn it over to this third corporation, what is the incentive of these two lay organizations?

DR. HAMILTON: The chief thing is the reliance put in the whole world between hospital and professional insurance. They don't like it to be, but it is in fact a tremendous sales gimmick to have Blue Shield hooked up with Blue Cross.

DR. HEDGPETH: May I make one comment? I would like to say, first, I agree with everything Alfred Hamilton had to say about the importance of Blue Shield.

I think we are discussing this morning a very serious matter, the whole area of medical care, that is, the attempt to meet the ever-increasing cost of medical care. The scientific aspects of the progress of medicine seem to me take care of themselves pretty well.

Granted Blue Shield is a tremendous sales gimmick, let me say. In true defense of hospitalization, I think I, in all honesty, must say this to you: Hospital Savings and the members of the Board of this Medical Society, have worked diligently and hard, and they have tried to do a good job. Hospital Care is doing a good job, but we have not between the two of us yet fully met the challenge and the need of North Carolina.

There was a time when Blue Shield was not a very popular thing to be aligned with in the eyes of the ranks of the profession. Hospital Savings Association has worked hard and had put over right around a half million dollars into the establishment of the good name of Blue Shield, in an attempt to help to do it; it couldn't do it by itself in North Carolina. It is a valuable asset to the Society. I have no objection to whatever is the best method to handle this thing for the overall objective which we all are interested in trying to meet, but I do say to you that this is a matter so serious that I think it requires very careful and thoughtful consideration.

When you take an asset and throw it away, one into which people have put much time and money, I think it ought to be done with very judicious and deliberate thinking.

PRESIDENT REECE: I am going to stop this discussion now and turn it over to Dr. Stubbs. Dr. Stubbs, I am glad that you were here to hear the comments that have been made. We know that you are here to be helpful to us, and we welcome you. The floor is yours, sir. [Applause]

DR. STUBBS: Thank you, Mr. President, Members of the Council and Guests:

I have already told your President and your President-Elect that I am grateful for any occasion that brings me to North Carolina, because next to my birth state of Georgia, and my home state of Virginia, I feel that North Carolina is closer to me and my family than any other. My oldest child, a daughter, started school and college in North Carolina, and we have been here for so many opportunities of a vacation stay over the years, and we love the people of North Carolina.

I would like to say initially, in commenting on a local problem, as an official of a national organization, that I am a states-righter by birth, and by continued concern to preserve local option.

So I am here today to offer you the assistance, as far as we can give it, of the national Blue Shield organization in gathering together the facts upon which you will make your determinations of what is good for the Medical Society of North Carolina, the in-

dividual physicians, and lastly, of the public whom we all serve.

I believe it would be appropriate to spend a word or two on the question of prepayment and its growth, its importance to us. Dr. Hedgpeth, I think, mentioned that the economics of medicine have become almost the paramount issue that we face as doctors, a kind of a paradox, it is true, but due to the fact that the changes in economics have been so much more rapid than those that we have been able to bring about in the scientific aspects of medicine and in patient care, that these changes of themselves coming at somewhat irregular rates in different parts of the country have left us in a state of confusion, and in rather a varied individual attitude toward what should be the part of the profession in regard to them.

As has been said here this morning, in very recent years, you, as individual physicians, and others of us practicing individuals, as I do in the District of Columbia, it happens now have had serious misgivings about doctors getting into what we call the insurance business, and I would feel today the same concern about being in the insurance business; but this situation has become something considerably more than the insurance business for doctors, and the best testimony to that is such figures as these, that 123 million Americans by 1958 count had some form of prepayment or health insurance, which is absolute proof that they are committed to the desire to support their medical care costs by a voluntary system of prepayment.

Twelve thousand of the physicians of this country are participating physicians in Blue Shield, every single one of them in a local Blue Shield plan which has its own autonomy of control.

The national Blue Shield organization is an association. It is similar to the American Medical Association, and we cannot tell our local Blue Shield plans more positively what they can do and what they must do than the American Medical Association tells you. I am sure you are concerned as a State Society with the overall attitude of American medicine as it is expressed by the American Medical Association. Your Blue Shield plan at Chapel Hill is concerned in the attitude of all Blue Shield plans, as expressed in the national Blue Shield organization. But we exercise influence rather, than control, because we are simply an association.

Now the one thing that we do have control over is the use of the name Blue Shield, and the sign and symbol which is patented. I might say that we have spent many hundreds of thousands of dollars, actually, over

the last decade particularly to protect our right to use that sign and symbol. Because it has been misused and used for profit, because it has become a valuable thing, as was mentioned, to you here in North Carolina—we have spent perhaps a half million dollars in developing the value of this sign and symbol—and to people everywhere, those who would use it for a profit would like to take advantage of this, and so we have had blue seal and every other kind of seal attempted to be used. It has been used for dog and cat hospitals, and for selling of plumbing equipment in New York, and things of that kind.

There is a controversy in Canada between a commercial insurance company and the Maritime Province Blue Shield Plan. This controversy over the value of this name is not confined even to the limits of the United States, but it has international implications. *It is a valuable thing because Blue Shield is known as the doctor's plan.*

Now I hasten to add that because of this local autonomy that we spoke of, the Doctors Plan is a variable thing. There are 65 of them in the United States, and they have, almost every one of them, a somewhat different approach to the relations of the medical profession and the plan.

We like to think of Blue Shield as being a sort of control point for a cooperative relation between the doctors of a community and their patients acting as an economic mechanism for paying doctor's bills, and it is a doctor's plan in that sense. Also it is a doctors' plan in the sense of the actual control of policy, for the most part, but that, too, varies.

It is true that of the 65 plans, 51 of them have boards of directors with a majority of the board made up of doctors of medicine. There are 861 doctors of medicine out of 1,403 board members on all Blue Shield boards combined in this country, but there is great variation. There are three or four boards where the entire board is made up of physicians. There are several Blue Shield boards that are fully the same as the organization which sponsors them, and there are a number of boards where laymen are in majority control.

But let me say this: that the doctors on Blue Shield boards, and the laymen on Blue Shield boards, very quickly come to have so strong a feeling and so real an understanding of their responsibilities in a public sense that it makes little difference actually in a smooth-running board whether the man has an M.D. degree or is a layman from the standpoint of performance.

What the M.D. degree does, and what the private practice of medicine does is to enable an individual to bring a special knowledge to the use of his board that can enable it to function more effectively.

The thing that we are facing at the present time is the challenge to make these mechanisms established and operating locally work across state lines. We have to preserve local fee schedules and local control, and yet because of the shifting population, the ease of transportation, communication being what it is, and because so many of the employer units that furnish the source of some funds to pay for health care, in part at least, are interstate organizations, the problem of national accounts has come to the fore, and except for the automobile industry, Blue Shield and Blue Cross have very little effective share of these national accounts, because we have not been able to bring our organizations into enough similarity of behavior to handle these accounts.

Our struggle to get a part in the Federal Employee Program was a very real one, but the biggest and most protracted difficulty with which I have had anything to do over the last decade as a Blue Shield official is still in private practice. The source of our difficulty was, more than any other one thing, the insistence of Blue Shield, my personal conviction that we should insist on retaining these local rights and options.

We have had to mold into a single unified program, one which is required by Congress, an act of Congress enacted into law by the President's signature, to make a governmentwide program. We have had to mold all of these differences together so that we can come up with one single figure which will represent the cost that a family, a federal employee and dependents, has to pay out to meet the costs of medical care for the hospital, the doctor part of the program, and the extended benefits; and this is a great deal of juggling, as you all will see.

In reaching this degree of national unity in Blue Shield, we have come face to face with local problems of varying magnitude. A number of these have, I know, interest here in North Carolina. Connecticut was one of the first places where we had to deal with a serious misunderstanding between the local Blue Shield plan and the local medical profession.

On the day that I and two other members of a committee went to Connecticut for the first time, we were given to understand that the government of the state had held off appointing a commission to arbitrate this problem only to give us a chance to

come in; but we went in only at the request of the State Society and of the Blue Shield plan. We are here today, I am here, at your invitation, but also because we have been invited by our Blue Shield plan in North Carolina, and by the applicant for Blue Shield status in North Carolina, to assist in in giving you the information that will help to guide your decision.

In Michigan I was supposed to have been at a meeting today—in Detroit—of a joint committee that was formed by the House of Delegates of the Michigan State Medical Society last September, after I appeared before the House, and suggested that they study this thing in their own way; but they have decided that they would like to have a committee of the House of Delegates, and a committee of the national Blue Shield acting to meet and try to reach a conclusion as to recommendations that would go back to the House.

I believe that while we here are deliberating the problem in North Carolina today, that the final stages of the solution proposed in Michigan will be effected in Detroit. But theirs is a problem not too unlike yours.

In Wisconsin we have what could be the end results of groups of doctors seeming to have contrary interests, and there we have two Blue Shield plans. Each one is actually the organization of the medical group, one the County of Milwaukee, the other the State of Wisconsin, and these two groups of doctors are the ones who actually are fighting one another. They have carried their fight to the AMA. It has been considered by the Judicial Council, and it has gone back to them without solution. They brought their request to the national Blue Shield at a meeting of our Executive Committee in Dallas, Texas, at the time of the last interim session of the AMA, and we have been attempting to mediate the matter.

The Federal Employee Program offered a certain amount of weight to our efforts to mediate there, and I believe that there is some progress being made. But once the bitterness of controversy of a civil nature between colleagues gets established, it is very difficult for anyone on the outside to come in and be helpful. You do not have that here, I am happy to say. I believe that my limited contact enables me to say truthfully that there is in this room every one of the elements of good will and desire to do the proper job that will make certain a good solution to your problem.

Let me go now very briefly to the situation in North Carolina and the comments that I would make initially upon it. The request for Blue Shield approval by the Durham Plan in North Carolina was respec-

fully received by the Board of Directors of the national organization. We were delighted to have the delegation from Durham come to Los Angeles. We hope that we did impress them with the sincere desire to do a proper thing, but to do it in a deliberate fashion, and to see that no mistake was made, because we don't have too many chances left to do the right thing in the economic fields of medicine.

In accordance with the conviction, first of all, that decisions of this kind are joint decisions of organized medicine, and of the Blue Shield groups that represent them economically, it would have been inappropriate for the national Blue Shield Board without more contact with this State Society to take an action which would have been unique in all of the Blue Shield movement, because up to now *there has never been approval of a Blue Shield plan knowingly established for the purpose of covering an area already approved.*

There were many questions that came up as to how this might operate if we did it. There were the questions, first of all, of the legal control of a Blue Cross board, however benevolent might be its attitude, to act for doctors who want a certain job done.

Now it is true that Blue Shield plans are not operated by boards that are all doctors, and it is not a selfish interest that can ever come into these operations without risk of defeating the very purpose of their existence. But, on the other hand, it is true, too, that a Blue Cross board, per se, must operate for the general interests of the overall program.

As Dr. Rhodes mentioned here a while ago, in connection with this whole problem of board function, it was recognized at the beginning in North Carolina that a board of trustees had obligations that could not be subverted by outside influence.

This State Society can recommend, through its insurance committee, to a board that it do certain things, and the board may do precisely those things as long as those things are in the common interest of the whole area that the board so directed has to operate. But also there is no control of a strict nature if there should be some other interest involved, and indeed a trustee may not delegate the responsibility for his acts to anyone else, and he may not receive instructions from outside as to how he would vote.

I have brought here today a number of reprints of a statement on the legal and on the philosophical implications of this which, at the moment, constitute a fairly accurate statement, I believe, of the national Blue Shield's understanding of this problem to which they subscribe.

The action in Los Angeles was not a rejection of the Durham plan, but it was a suggestion that we continue to study this, that we do what you are doing and try to get all of the facts together so that we could operate. Also let me say that there was no action of intervention, or of attempt in any way by national Blue Cross to influence national Blue Shield. I have stated publicly on many occasions that national Blue Cross and national Blue Shield have operated in their areas, particularly in regard to federal government relationships, in as close and effective a teamwork as I have seen over the years. But I can truly say to you that neither organization has attempted, to influence the actions of the other in those matters that are peculiarly district as being Blue Cross or Blue Shield, and although here we have two Blue Cross plans that are concerned, the national organization had nothing whatever to do with the actions of the national Blue Shield.

This was not an effort on the part of our board to place a distinction between the Durham and the Chapel Hill Blue Cross plans. We do have, as you recognize, an obligation to a Blue Shield plan already in existence licensed, so to speak, for many years to use the Blue Shield sign and symbol, and our rights to transfer that would be limited rights. Exactly what they are, I wouldn't pretend to say at this moment. It would have legal implications.

At any rate, we do have these obligations to protect the rights of the Chapel Hill plan, just as we have the moral obligation to protect the rights of the doctors' interests in the Durham plan. So our problem of authorization to use the Blue Shield sign and symbol is a complicated one. It depends upon your approval primarily, but it also depends upon our obligation not to attenuate the value of these rights by spreading them too thinly.

The decision that we made was one to study because we know the history of this problem as it has been outlined to you, at least in a superficial way.

We would feel quite proper in proposing to you that you join with us in some degree at least in studying the matter before you arrive at your final solution, because we think we have in one spot the information of what has gone on in other areas that would be helpful to you in solving the problem, and since the responsibility overall is a dual one, too, we feel that it is fair to ask that you associate yourselves with us in some parts of this decision.

We don't pretend to know the answer as to just how this can be done. Dr. Johnson mentioned a number of possibilities, wheth-

er you would have a new corporation which could use agency agreements for a job. (administrative) or whether you could even conceivably use your present Blue Shield corporation and authorize sale of a given approved contract elsewhere—you might change the board of that one so that you had a more effective control of the Blue Shield part of it. You can separate the Blue Shield part from the hospital part.

In this connection, I would remind you that the doctor's part of a program is not confined to the service benefit to the patient, and that segment of the contract only, but a proper Blue Shield plan embraces all of the contracts that pay for physicians' services in whole or in part to patients.

I would remind you also that North Carolina is in a position here, if you solve this problem well, to extend not only the value of Blue Shield as an economic arm of the medical profession in this state, but to act as a leader in the South where leadership is needed in this area.

Our efforts have been sporadic, inconclusive, and ineffective all over the South in this area, and we don't have a strong Blue Shield program, except the one that is beginning to grow up in the State of Florida, that operates statewide and in an effective way.

You can and should exercise a leadership here that you have as a progressive state in many other ways, in my opinion. I said I wouldn't tell you what you should do, but it is always fair for anybody whose ancestry included more preachers than doctors to exhort you to do the proper and moral thing, and that I now do.

I don't think I should say anything else at this time except to associate myself completely with all of the ideas that have been expressed this morning for studying this matter carefully, because, believe me, the time is really running out for doctors to do something that will enable them to exercise some control in their future.

You are all aware of the fact that the Federal Employee Program, although the government there was acting as an employer for five million-odd employees with their dependents, is the largest prepayment program in the world, going into effect July 1st. But you are not quite so aware, perhaps, although it has been talked about in great degree, that whether the Forand Bill or the Flemming Bill, or the Kennedy Bill in the Senate, should pass, or whether any version of these should pass, the thing that Mr. Flemming took with the approval of the President to the Ways and Means Committee last Tuesday would give a prepayment

program or a similar type of operation at state level in the aggregate which would involve government funds ten times greater than the entire Federal Employee Program.

Now the fact that this came out of the White House, approved by the Cabinet, it is a political gesture we know, but also it places the Republican Party and the Democratic Party both officially behind programs that start at a billion and a quarter dollars of proposed governmental outlay to a segment of the people that furnishes 16 million votes.

So don't kid yourselves at all, and I do not kid myself, that 175,000 doctors can vote heavy enough to control this. Unless you have got a thousand votes in your pockets of laymen, don't pretend that you can control legislation in this country, because that is just about what it takes per doctor to do it.

Well, if we can't control those things, then, for heaven's sake, let us, all of us as doctors, try to have a program to which we can subscribe, and in which we have a voice and control that will enable us at least to influence in significant degree the way these things are done, even if we cannot prevent their being done. [Applause]

PRESIDENT REECE: Thank you, Dr. Stubbs.

DR. AMOS JOHNSON: Mr. Chairman, I believe that it has been well expressed—I know it has been well expressed by Dr. Stubbs, and that others have expressed the same thing—Dr. Hedgpeth did, and others of us—that this is quite a big decision that we are working toward; and in order to crystallize the thinking of this group here, this Executive Council, I would like to make a motion that the Executive Council approve the appointment of an ad hoc committee, this committee to be composed of members of the Executive Council, of members of the now present and operating Blue Shield Committee of the State Medical Society, and of members of the two operating nonprofit plans within this state, of members of the medical directors of the two now in existence operating nonprofit plans. Hospital Care and Hospital Saving, the purpose of the committee to be to study this situation diligently and to avail itself of all possible sources of information which might lead to a proper solution and to a proper recommendation from this committee to be made back to the Executive Council at its fall meeting, and that the House of Delegates be made aware of this action of the Executive Council, if it follows through on this, and that their approval be solicited.

PRESIDENT REECE: You would make

that recommendation to the House of Delegates tomorrow?

DR. A. JOHNSON: Yes;

[The motion was duly seconded.]

PRESIDENT REECE: Discussion?

DR. BAKER: If we take this to the House of Delegates, as I said here a few minutes ago, I heard the word "rights" used several times; I heard the value of Blue Shield as a gimmick used several times. I heard Dr. Hedgpeth say that Hospital Saving spent \$500,000 in building up Blue Shield.

Actually, I don't think that we people sitting here as doctors, considering the Doctors' Plan, have anything in mind but one thing, to bring in more service to the people of North Carolina for good medical care. That is our only interest.

As for the rights of Blue Shield, if Blue Shield is to become valuable through advertising, through public relations, any cost that was involved in developing that value was money that was collected from the citizens of North Carolina and it was not hospitalization money. It was the people's money.

Any value that Blue Shield has now has been built the same way, and I think when we make our decision, with all due respect and without any prejudice whatever for one company or another, we must remember that we only have one thing in mind, and if the people's purposes are going to get in the way of the rights to service that our people need, we will have to trample on some of those purposes in some way. I know not how. But we have one goal.

PRESIDENT REECE: Dr. Koonce, in relation to your statement concerning the action of the House of Delegates on this, if the Executive Council approves this, we would like the approval, I believe is my understanding, of the House of Delegates before that committee is appointed.

DR. KOONCE: Do you want them made aware of it, or would you like for them to take action on it?

DR. A. JOHNSON: I would like for them to take action on it; I would like them to approve it. That would be my personal opinion.

DR. KOONCE: Dr. Reece, that would come under your report of the committee.

PRESIDENT REECE: Yes. We have invited Dr. Stubbs to stay over and he has agreed to do it very generously, to go to the House of Delegates tomorrow and help to inform all the members of the House of Delegates as to the gravity of the Problem as it confronts the nation and also the development of an adequate Doctors' program in North Carolina, and Dr. Stubbs will be

here as our guest today and through tomorrow.

If he is kind enough and could make the arrangements, I know that he will be glad to talk to all of us from time to time informally and help us out of the dilemma that we are in.

Are there any other questions you would like to present to Dr. Stubbs?

DR. BREWER: While we have Dr. Stubbs here, and we are all here, I would like to ask him if there are any plans operating in the country that have a third corporation such as we are talking about setting up here, and something about the expense of operating such a thing through the Medical Society.

DR. STUBBS: The Blue Cross was the first to set up corporations in this area, and in most areas the hospital program was already operative, and financially sound, or at least it had some financial backing when Blue Shield was started, so that in so many areas, as in the District of Columbia, which I think is somewhat a typical one, the Blue Cross Plan there was not originally a Blue Cross Plan. It was started by a group of local citizens and was not a hospital plan. It began 26 years ago. They attempted, from the Medical Society about 16 or 17 years ago, to get a Blue Shield Plan or a Doctors' Plan started unsuccessfully, because they didn't have the financial backing, and the Blue Cross Plan wouldn't agree to arrangements that the Society thought they needed.

After a few more years of deliberation, they did begin what is now the Blue Shield Plan, and they began it by setting up a corporation for the purposes to which we subscribe in these plans. The corporation was a nonprofit one. There were 25 incorporators, I believe, and they established a board of directors of eleven men with physicians and laymen. There were seven of the eleven who were physicians from the District Medical Society, and they entered into a contract, an agency agreement with the Blue Cross Plan, to operate this program for them.

They operated it paying the operating expense and doing all of the work but keeping records of the administrative costs during the early years. That operating agreement is still in effect in the District of Columbia. We have a separate Blue Shield Board which determines policies for Blue Shield, but the Plan has grown to cover according to the national figures more than 65 per cent of the eligible population—and when I say eligible, I mean those who are not indigent—and it still is operated by Blue Cross.

Our first employee in the Blue Shield Plan of Washington, D. C. was the Executive Vice President hired to be our executive two years ago. He still is the only employee we have. Our records are kept by our Board, but our agency agreement requires that the Blue Cross do the entire operation for us under the terms of the agreement. We determine all contracts. Every change in income level for the service benefit program and every single fee for physicians' services is approved by the participating physicians of that area.

At the present time, there are 2,402 participating physicians that involve the five adjacent counties in Maryland, Virginia, the District, and the rights to operate the Blue Shield Plan are ceded formally and legally in the State of Virginia to the area of the metropolitan section of Washington, and informally by agreement in Maryland; but our areas don't overlap officially with the adjacent state Blue Cross and Blue Shield Plans.

Now this is a plan beginning as a corporation in its own right but operating entirely through agency agreement with the Blue Cross Plan.

In the South, for the most part, Blue Shield has been operated by Blue Cross within the Blue Cross Board. In the State of Florida, which I mentioned as being a strong plan, and one where there has been a great deal of effort to advance this plan in the last several years, they have a separate board, but they, too, operate the Blue Cross Plan as an operating agency. There is an economic advantage to having one single office do the work for Blue Cross and Blue Shield programs, but there is an advantage in having control in separate corporations, as most Blue Shield plans have found it.

In some instances, the Blue Shield Plan has started as a Blue Cross; it has gradually separated and it has gotten a separate board, and then it takes on a separate organization, and in just a very few parts of the country, it has become an entirely separate entity, as in the State of Connecticut, where Blue Cross and Blue Shield have separate buildings; they operate entirely separately.

In the State of California, Blue Cross operates physician and hospital service programs, and Blue Shield does the same thing, and both are in direct competition for the full gamut of medical care coverage throughout the state. So you have really as a precedent anything on earth that you want to follow, and you can find that it is already being done in this conglomerate list of associations. But you can have a board that can operate officially and legally as an

agency, and it can do it with agency agreements, and that has been done in many places.

PRESIDENT REECE: Thank you, Dr. Stubbs.

I failed to put the motion before the house. You heard Dr. Johnson's motion, that we appoint a committee, that we recommend to the House of Delegates that they approve the action of this Council in establishing a committee to study this and to report back to that committee and give them the authority to act. Is that right, Dr. Johnson?

DR. A. JOHNSON: Right.

PRESIDENT REECE: That has been seconded. Any other discussion?

[The motion was put to a vote and carried.]

That will be a part of our report then to the House of Delegates.

Thank you, Dr. Stubbs, and I hope you will make yourself at home.

PRESIDENT REECE: We are going to reconsider some of the reports of the Committee on Constitution and By-Laws after we had time to read that last night. We took several actions concerning things on that, and I think it has been clarified.

Dr. Paschal, you were going to look into one or two of these things. Do you have any questions concerning this?

DR. PASCHAL: No, John, I had nothing to consider.

SECRETARY RHODES: Mr. President, there is one matter that is not involved in this report that I would like to bring up here, if it is proper to bring it up. There is a question of dual membership in county societies.

There is nothing in our By-Laws at the present time that covers this point.

The only thing in the By-Laws that might apply, and that is that a man living in one county who finds it convenient to belong to another County Society because of residence perhaps, or the area in which he practices, may with the permission of the County Society have jurisdiction, join another County Society.

Now the question that I raise is whether or not we should have something in our By-Laws covering such dual membership, and I want to bring that up because I think it is a point that is going to be raised more often now that we are getting more and more widespread hospitals being built.

PRESIDENT REECE: I will contact Dr. McMillan tonight and review this thing, and if so, you will be notified.

DR. SAMS: That thirty-minute meeting in the morning then would take care of it, don't you think?

DR. A. JOHNSON: Not speaking to that, I want to speak one more minute to the Mecklenburg situation. I would like to make a motion that the President, the Constitutional Secretary, our legal advisor, and the Chairman of the Committee on Public Relations prepare a written and considered statement to read or to present to the press regarding this.

DR. SAMS: That is a good idea. I second the motion.

PRESIDENT REECE: You have heard the motion and it is seconded. All in favor say "aye"; opposed "no." It's carried.

Concerning the meeting of the Council tomorrow, if there will be one, you will be notified, but I doubt if we have to have one, Dr. Sams. Unless Dr. McMillan definitely wants one, we will not have a meeting of the Council.

DR. SAMS: That's all right with me.

PRESIDENT REECE: The next item we will go to on the Commission reports is (c). I believe we are down to that, aren't we? Annual Convention Commission. Dr. Rainey is not here. Is there anything new to add?

DR. AMOS JOHNSON: I have something, Mr. Chairman, that I wanted to bring up, but I suppose it would be better under new business, or it could be brought up here. It pertains to the annual convention.

I have a resolution that I would like to read and hear you all discuss. It says:

Whereas, Article II of the Constitution of the Medical Society of the State of North Carolina which reads:

Article II—Purposes of the Society

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of North Carolina, and to unite with similar organizations in other states to form the American Medical Association with a view to the extension of medical knowledge, and the advancement of medical science; to promote friendly intercourse among physicians and to enlighten and inform the people with regard to the great problems of medical care and public health, so that the profession shall become more capable and honorable within itself, and more useful in the prevention and cure of disease, and in prolonging and adding comfort to life.

outlines clearly the purposes of this Society; thereby implying the purposes of its annual session, and

Whereas, That portion of Article II dealing with those purposes such as, "The extension of medical knowledge and the advancement of medical science—the prevention and cure of disease and in the prolonging and adding comfort to life" is

now greatly implemented within the framework of this Society by post graduate educational facilities of our three medical schools, by the many medical symposia and seminars conducted within this state, and by the scientific sessions of the many specialty societies existent within this state, and

Whereas, That portion of Article II dealing with those purposes such as "To federate and bring into one compact organization the entire medical profession of North Carolina—to promote friendly intercourse among physicians, and to enlighten and inform the people with regards to the great problems of medical care and public health, so that the profession shall become more capable and honorable within itself," is deserving of more time and attention at this Society's annual convention, now therefore be it

RESOLVED, That the Annual Convention Commission of this Society be instructed to alter the program format of the Annual Sessions, within the framework of the present Constitution and By-Laws of this Society to produce Annual Session programming containing continuity of thought and of broad scientific spectrum sufficient to be of interest to all doctors of medicine: this not to the exclusion of proper consideration of the socio-economic aspect of medicine.

I make that recommendation, as a motion that this Council approve and that it be submitted to the House of Delegates. I would suggest that the House of Delegates has the authority to set up a reference committee, and that a time might be set for a hearing on this, and the reference committee report back to the House of Delegates at its second session the findings and the will of the membership of the Medical Society.

PRESIDENT REECE: You have heard Dr. Johnson's motion. Is there a second?

[The motion was duly seconded by Dr. Squires.]

PRESIDENT REECE: You have heard the motion.

DR. NORFLEET: I haven't heard enough discussion. I wish Dr. Johnson would enlighten us on what is behind his thinking here.

DR. AMOS JOHNSON: I realize that it will take discussion, and I was hoping for expediency that most of it would be before a reference committee. The thinking back of it is basically this: That as a Medical Society involving all doctors in all specialty groups, general practice being in the specialty groups; that we are becoming fractionized as a State Society, and that we have ade-

quate sources of scientific information with these various seminars and medical school programs, and extension programs, and post-graduate programs which we have, and that as a gradual trend over the years, the trend has been to permit of too much specialty section emphasis within the context of our annual meetings; that we are meeting now more actually as specialty groups within the framework of our State Society than we are meeting as medical doctors. If medicine is ever socialized or put under government control in any manner, it will not be done on a specialty basis; it will be done to all of us at one time as doctors of medicine.

Therefore, since we now have access to sufficient scientific information so that we do not necessarily have to have specialty sections at our annual meeting, it was the thinking of some of us who have discussed this that we might set up excellent general sessions with continuity of thought, I mean so that it would be of interest to surgeons, to internists, to endocrinologists, dermatologists, and all of them.

We might have continuity of medical content programs that everyone would come to instead of what we have now. If you will look at our programs for the past several years, one thirty minutes will be a speech on ring worm infection of the scalp, the next thirty minutes will be on pylorostenosis in babies, and the next one on something else, and you have just a constant shift of those coming in who are interested in that one little bit of a program, and it becomes embarrassing to ask people to come and talk to you when we have anywhere from 25 to 50 people sitting and listening to them.

It would be possible to produce a program that would be of such interest that we could have people come in as doctors to go to this program and have it of interest to them, and also include in the program some of the socio-economic and political aspects of medicine, so that we might bring ourselves together once more as medical doctors for our annual state convention, rather than as sectional specialty groups.

You know, and I do too, that at this meeting there will be people who will come only Tuesday afternoon or Wednesday afternoon or Monday afternoon when the specialty section meets, and will not attend any portion of the general sessions, and will go back home and will say they have been to the State Medical Society Meeting.

We were just trying to re-evaluate things and bring it back into proper perspective and have us all at one time during the year meet as doctors and not as fractionated

groups within the State Medical Society. Does that explain what we had in mind?

DR. NORFLEET: It does, and I wonder if this goes far enough, in view of the previous discussion of another problem which will not only face us this year, but in continuing years even more, whether this thought might not encompass definite plans for marked variation in our annual meeting to take care of those exigencies which no doubt will beset us in the years to come. Should not that also go along with this?

PRESIDENT REECE: This reference committee that you are talking about could study all of these things. In other words, you wish this resolution to go to a reference committee?

DR. AMOS JOHNSON: I wish, Mr. President that it be referred from the House of Delegates to a reference committee, set up a reference committee to deal with our annual session meeting, and that it be advertised to the House of Delegates and to every member of the State Medical Society as best it can be where the hearing will be, and when the hearing will be, so that all may come and express their opinions.

I had originally asked Mr. Barnes to set it up so that I could try to appear before each specialty section for a period of two or three minutes, and try to explain this to them and get their approval individually. Then, on second thought, it occurred to me that it would be better handled this way, when all could get together and have a coherent discussion of the whole thing.

PRESIDENT REECE: In other words, you would make the suggestion that we get this committee appointed tomorrow afternoon.

DR. A. JOHNSON: That's right.

PRESIDENT REECE: That committee will announce that they will be in session sometime Tuesday morning.

MR. BARNES: Dr. Johnson, I wish to say that all sections have been notified that you will appear before them, and several of them have responded giving a specific time, and I have placed in your box here that information, so that you could schedule where you were going.

DR. A. JOHNSON: I would then contact, or attempt to have your office contact all of the section chairmen, if this were approved.

PRESIDENT REECE: You have heard the motion, and it is seconded. Is there discussion?

[The motion was put to a vote and carried.]

PRESIDENT REECE: The report of the Professional Service Commission.

DR. PASCHAL: Mr. President, the Professional Service Commission report has been presented in the greater part to the Council before, and each of these six committees have little to add, other than what you have heard at a previous meeting. Each of the committees was pleased with the arrangement at Pinehurst for the committee conclave, and they felt that it exemplified the operation of the committee.

First I will speak about the Committee of Insurance, of which Dr. Joe Hooper was Chairman. This Committee has done well; it has met three times during the year. The only thing that we have to add, in addition to what you have previously heard, is the fact that the Commissioner ordered a rate reduction for this type of insurance through the burea participating companies in North Carolina. This reduction was accomplished, and the St. Paul Mercury Indemnity Company provided us with a second reduction within the year.

The Committee feels that the liability program quoted by this Society offers the most favorable benefits, and it is to our advantage, we think, to continue to try to secure additional participation by our membership.

In regard to a matter that was raised yesterday, in that the Academy in Greensboro had elected to form a panel of physicians to work with lawyers on problems of medicolegal importance, it is the intent of this Committee—and in some areas it has been done—to establish local panels to consider technical problems that are coming to litigation and to offer to make recommendations concerning them. They in turn work with the lawyers representing the defendant in this technical situation of need.

That's being worked on, and that's being expanded, and we anticipate that that will make it unnecessary for these individual organizations to try to set up their own panels on the local level. We hope that they will feel that they can work with the Society as a whole, and we believe that that would offer an advantage rather than having it broken down into small segmental groups.

The Committee on Eye Care and Eye Bank, of which Dr. George Noel is Chairman, has nothing new to submit at this time. They have no specific recommendations to offer.

The Physicians' Committee on Nursing, of which Dr. Robert Cadmus of Chapel Hill is Chairman, have met three times during the year, suffered the loss of one of their more distinguished members in Dr. Moir Martin, and we all regret that. They continue their work and have nothing specific to recommend.

The Committee on Post-Graduate Medical Study of which Dr. Samuel L. Parker is Chairman, also has no specific recommendations. They do report on their work, and I believe that most of this has been submitted to you heretofore.

The Committee on Necrology continues to function and carry out its routine work. They did make a recommendation concerning the change of time of the memorial service, but it was rejected, and if there is any further consideration of that, the Committee has not at this time prepared a proposal that it be reconsidered.

Finally, the Committee on Emergency Medical and Military Service has little new to report. As far as the military affairs are concerned, there has been no problem during the past year concerning that. The Committee has worked in conjunction with the Office of Civil Defense here in North Carolina, and only recently I attended rather late, but was briefed in the operation that was carried out last week on a national basis in which our Civil Defense Department participated and our Committee was represented at that operation on a state level.

We are working in conjunction with them, and our plans are being developed in more areas as time passes. More of these 200-bed unit hospital facilities, equipment, and so forth, are being stored in strategic areas in North Carolina. We have 21 or 22 stations for mobile hospitals at the present time. We have applications for four more, which will be further dispersed at strategic points.

There is only one objection that we find from our Director of Civil Defense, General Edward Griffin, and others who are interested in this thing, and that is the apathy on the part of doctors in a great many areas to participate in this program, and their failure to come up with any positive concrete evidence that they are locally prepared.

Most of the communities have mass casualty programs written out and spelled out, that is, in our larger areas. Smaller areas are not so well equipped for it, nor do they have plans for it. I think that we ought to continue to urge them to participate. They are doing it on a broader basis all the time, and I believe that will bear fruit in the long run.

The Committee itself has no specific recommendations to make to the Council, other than to bring them a report of the activities. Thank you.

PRESIDENT REECE: You have heard Dr. Paschal's report of his Commission. What is your pleasure with it?

DR. SAMS: I move it be received as information.

[The motion was duly seconded, put to a vote and carried.]

PRESIDENT REECE: Thank you, Dr. Paschal.

Next is the Public Relations Commission.

DR. BEDDINGFIELD: Mr. President, Dr. Poteat asked me to make his report for him. There is no additional report, except a brief item I have which I suppose comes from the Public Relations Committee. This will take about three minutes, and I will read it.

At the January, 1960, meeting of the Executive Council of the Medical Society of the State of North Carolina, it was brought to the attention of the Council by a delegation of physicians from Harnett County that apparently a situation has arisen wherein various local city and/or County Health Departments in the State have established, or plan to establish, dispensaries with the purpose of dispensing drugs to persons utilizing the facilities of these Public Health Units. Apparently this program has been encouraged, if not promulgated, by the State Department of Public Welfare. Presumably, the attempt to justify such a program would be on the grounds of furnishing drugs, especially the more costly ataraxic-tranquilizer medications, to persons thought to be medically indigent.

The Executive Council expressed concern at the possible implications of such a program, feeling that there were dangerous potentialities in such a program affecting both the medical and pharmaceutical professions; that there was a definite public health hazard and possibly a violation of law probably under such a program wherein ancillary personnel of the Health Department (nurses, secretaries) would in all likelihood be involved in the dispensing of potent medications; and that there were obvious economic dangers to the taxpayers of the State. Following deliberation of the problem, the Council took action empowering the President to appoint a member of the Council to initiate a joint medical-pharmaceutical investigation of the problem, and to subsequently submit recommendations as to policy.

The undersigned Council member was appointed by President John Reece to launch such an investigation. On March 23, 1960, I met at the State Medical Society Headquarters with Dr. Bruce Blackmon of Harnett County; Mr. W. J. Smith, Executive Secretary of the North Carolina Pharmaceutical Association, Mr. H. C. McAllister, Secretary of the North Carolina Board of Pharmacy, Mr. James T. Barnes, and Mr. William N. Hilliard.

At the conference, it was learned that the Board of Pharmacy was very concerned not only about the distribution of drugs through local health units, but also by the other "unorthodox" systems, such as the State Mental Hospitals, certain industrial health units, mail-order prescription services, and so on. It should be noted here that the pharmacy representatives at this meeting were pleased that the Medical Society has taken official cognizance of this problem of unorthodox drug distribution. It developed that the Board of Pharmacy was just beginning to survey to determine the nature and extent of such unorthodox drug distribution systems, and that it would be desirable to have the results of such a comprehensive survey before any significant action could be taken. It was felt that the Medical Society could be of immeasurable help, at this time, by having county Medical Society officers cooperate in this survey by having them complete a questionnaire relating to the present policies of drug distribution in their respective counties, especially by the local health departments. Accordingly, such a survey questionnaire has been prepared, and if the Council approves this report, it will be sent to component county society officers.

I have maintained liaison with the Pharmacy representatives since our March 23rd conference by telephone and by correspondence, and I have learned that the Attorney General has ruled that out-of-state mail order prescription services are in violation of the Pharmacy Act of this State, and the Board of Pharmacy is presently sending orders to cease and desist to all such firms known to be sending prescription-type drugs into this State by mail.

Also, Mr. McAllister has prepared a manuscript entitled "Mail Order Prescription Services" wherein he attempts to define the magnitude of this problem at this time in this State; he points up inherent dangers of such a system, some of which might not be readily apparent to physicians as to pharmacists and which therefore need to be as pointed out to physicians, and he cites other disadvantages of the mail order business. It is my recommendation that this manuscript be submitted to the Journal of the Society for publication.

I further recommend that this Society continue close liaison and cooperation with the representatives of pharmacy in the effort to survey this entire problem of unorthodox drug distribution to the end that specific policies might be formulated between the two professions.

I further recommend that the following statement of policy be adopted by this

Council at this time and sent to the North Carolina State Board of Health, the State Health Officer, the various local Boards of Health, the Commissioner of Public Welfare, and the local Welfare Boards.

"The Executive Council of the Medical Society of the State of North Carolina has had its attention directed to the apparent trend of establishing dispensaries in local county health departments for the purpose of supplying drugs to individuals presumed to be medically indigent. This Council is presently cooperating with the North Carolina Pharmaceutical Association in making a survey of the various methods employed all over the State for the procurement of drugs for the medically indigent. At the conclusion of this survey, it is anticipated that recommendations will be made for the development of a uniform plan for furnishing medication to indigents, which plan will probably utilize the traditional facilities now available for the distribution of drugs. It is apparent to this Council that the widespread practice of dispensing potent medications in county health units could eventuate in a situation dangerous to the public health because of the general unavailability of registered pharmacists in such local health units. There are also possible economic pitfalls in such a drug distribution system. The proper functioning of local Health and Welfare Departments almost requires the daily cooperation of pleasant liaison with the local physicians and pharmacists and the establishing of dispensaries could tend to alienate these professions.

Therefore, this Council strongly urges that no action be taken to develop this plan of dispensing drugs in local health units at this time, pending the results of the medicine-pharmacy study of this problem.

I move the adoption of this report and this resolution.

Respectfully submitted,
Edgar T. Beddingfield, Jr., M.D.

[The motion was duly seconded by Dr. Amose Johnson.]

PRESIDENT REECE: You have heard the report and the motion. Are there any questions?

DR. BEDDINFIELD: It was felt, before you vote, that although it is fine to have a survey, I think we should have all the facts before we come out with a definite plan; I think that we can recognize this as a dangerous situation, and register a protest as of this moment.

Now the retail pharmacist, represented by their association, Mr. Smith, have indicated that they are willing to work out a plan for serving welfare patients, accepting

less than the regular retail price for their prescriptions if they are certified by their welfare units and handle it through the traditional retail drug outlets, and not have these drugs in every health department.

I think we should work out a plan, but I don't think it is premature to at least register an objection to having drugs in the county health departments. That's the reason for my resolution.

DR. THOMAS MURPHY: Rehabilitation is doing the same thing. I don't know whether they get it through the Public Health Service or not. They have been dispensing some drugs in our county.

DR. BEDDINGFIELD: This is the only thing you can do at this time, just to register our protest that we do not approve of this.

DR. SAMS: I think our Executive Secretary of the American Academy of General Practice stated flatly what we could very well afford to endorse here, that we as a profession firmly state that there is no gap in the pharmaceutical profession or the medical profession. I just think we ought to do that for our friends in the pharmaceutical world too, if Dr. Beddingfield would be kind enough to add that to his report.

DR. BEDDINGFIELD: I certainly will.

PRESIDENT REECE: Do you accept that as an amendment?

DR. BEDDINGFIELD: I do. The amendment is accepted by Dr. Johnson.

You have heard the motion. Any discussion?

[The motion was put to a vote and carried.]

PRESIDENT REECE: Next the Commission on Public Service, Dr. John Robert Kernodle. You have been very patient.

DR. KERNODLE: As a report on the Service Commission, I have twelve committees that have been very active during this year. The complete report is in the compilation and I do not intend to go over all of the details and their recommendations.

I do want to pick out some actions that have been taken since these reports were made. First, I would speak to the Committee on Cancer. There has been a recommendation that this Council know that Dr. Mark Lindsey directed and proposed and put on the first Cured Cancer Congress in North Carolina last month. It was very successful. Some 164 delegates and alternates appeared in Raleigh from 59 counties. It is the purpose of that to make known that cancer can be cured, diagnosed and treated early, and they recommended that you be aware of Dr. Lindsey's activities in this field.

The next committee addendum would be on Child Health. Last September, they proceeded to recommend expansion of their program and asked for additional funds. The action on these additional funds was tabled until more information was obtained. At this time, I would like to request that the budget be increased from \$1,182 to \$1,272 for this year for the Child Health Program. That is a total of \$90 increase for the year.

If you would like to take action on each one at this time, it would be fine.

PRESIDENT REECE: You have heard this request.

[A motion to authorize the request was seconded by Dr. Baker, put to a vote and carried.]

DR. AMOS JOHNSON: If you are taking them up individually, in reference to the report on the Cured Cancer Clinic, I have been told that Dr. Mark Lindsey is preparing to leave North Carolina to do more extensive work in the field of cancer, cancer diagnosis and cancer treatment, and since he has done so much work and such excellent work, I feel and so move, that it would be appropriate if this Council, through the President, wrote him commending him on his work, and commending him on his further interest in the field of cancer, and expressing the hope that when he has completed his studies that he will then return to the State of North Carolina to continue his work.

DR. BEDDINGFIELD: I would like the privilege of seconding that.

PRESIDENT REECE: You have heard the motion and second.

[The motion was put to a vote and carried.]

DR. KERNODLE: On the Committee on Chronic Illness, this Committee has been extremely active, right up until the last week when we had our last meeting. This followed a subcommittee meeting with the State White House Planning Conference and also the AMA White House Planning Conference was held two weeks ago, and from this we took up the information that was obtained.

There are four recommendations that this Committee would like to bring out at this time. *First*, that it be publicly known that the physician's interest is to serve the health and medical care needs of all persons, regardless of age or ability to pay for services. This approach will deemphasize the public appeal for increased medical services just for the aged.

The intention of that section is to bring out the fact that we are giving medical care and service to all indigent patients in North

Carolina. We need to publicize that more.

Do you know under "miscellaneous" on the agenda there is a heading "Newspaper Clipping from Charlotte." That particular clipping refers to the fact that Dr. Dave Welton reported from the Mecklenburg County Board of Health, which he chairs for the Medical Society in that particular Board, that they were giving and would continue to give free medical service to all people over 65 as well as those in all age groups. We wanted to emphasize that type of educational program to the public.

The (b) recommendation was that each County Medical Society officially designate one delegate and one alternate to the July State Conference on Aging, the Governor's Conference. That would be intending to have medicine well represented in this particular area of activity. We find that throughout the states there is a lack of interest of the doctors in this program. Fortunately, in North Carolina, we have been most interested and have obtained a definite rank in this Commission, worked on the White House Conference both statewide and nationwide.

It so happens that we have been able to obtain 15 doctors on the 8 subcommittees of the Commission on Aging in its planning for the White House Conference. We are now in the process of getting delegates to the White House Conference in January of 1961, and I may bring up under new business—at this time consideration of the expense of these delegates to the White House Conference on Aging in January, 1961.

The expense for the delegates to the January, 1961, Conference should be defrayed by the State Medical Association.

PRESIDENT REECE: Do you wish to present that now as a recommendation?

DR. KERNODLE: Yes.

PRESIDENT REECE: Have you an estimate as to the cost?

DR. KERNODLE: We don't know how many delegates we will get.

MR. BARNES: I think out of a total of 48 delegates allocated to North Carolina (that is our understanding), we would probably do well if we got 10 or 15 of that 48. I mean we would be doing extra well.

So I think the Conference being held in Washington, which is not too far away, that you are not going to have a very heavy individual expense, and that the Council probably ought to approve anything up to 15, but with the real prospect of their being about seven delegates. Does that sound logical to you?

You would have to be in Washington three days. There will be about \$60 trans-

portation by air, and about \$18 or \$20 a day.

DR. PASCHAL: About \$100 per person.

DR. AMOS JOHNSON: Mr. Chairman, I would make a motion that each medical delegate to the White House Conference in January of 1961 be reimbursed up to and not to exceed \$100. That means not necessarily that he be given the \$100, but that if it is less than the \$100, he be reimbursed in full. If his expenses exceed \$100, that he makes up the deficit himself.

[The motion was duly seconded by Dr. Sams.]

PRESIDENT REECE: Are you going to put a limitation on the number?

DR. A. JOHNSON: The Governor is going to limit that, I am afraid, too confoundedly close.

[The motion was put to a vote and carried.]

DR. KERNODLE: The next point also is an expense program. The Committee felt that this was a most important program in July of this year, the State Conference, and likewise we felt that it was necessary to obtain excellent press coverage, and recommended that the Council engage the services of an expert press potential for this program in July and bear the expenses of the same. It was thought that probably \$500 would be necessary to hire such a man or agency.

PRESIDENT REECE: Do you make that as a recommendation?

DR. KERNODLE: I do. The Committee made that as a recommendation.

It was felt by the Executive Director, Mr. Barnes, that we needed some outside coverage, with the use of our own public relations personnel, too, that it would be worth while to see if we could hire someone from the John Harden agency or a like press agency for this particular program.

A motion to authorize an expenditure of \$500 or less for Public Relations Counsel was made.

[The motion was duly seconded by Dr. Sams.]

PRESIDENT REECE: You have heard the motion made and seconded.

[The motion was put to a vote and carried.]

DR. KERNODLE: The fourth portion of this Committee's additional request was that we consider and accept the recommendations of Dr. Stanford and his group in regard to increasing the state pool fund program, the per diem hospital cost for indigent care. In this particular area there has been a lot of discussion in the last five years, I understand, by Dr. Stanford and the Committee.

In regard to this, it means that we have been from year to year recommending an increase in the amount of money that the

state allots for matching funds to take care of the per diem cost for pool fund patients.

At the present time the state, with its matching funds on a federal basis, 65%, 17½% state, and 17½% local, is taking care of \$10 per day on hospital cost. Dr. Stanford's recommendations were presented to the subcommittee of the White House Planning Conference, which is going to be held in July, and they accepted this recommendation.

Our Committee also felt that it was wise that we accept the same. His figures on the cost may be a little off actuality, but there are monies in Washington available. We would have to recommend to our General Assembly that they increase the funds sufficiently great to make 100 per cent payment of actual (reimbursable) cost in the hospitals.

To bring you up to date, the Blue Shield-Blue Cross program at Chapel Hill says it costs \$24.50 per patient of the indigent variety, that is their average cost. Ten dollars per day is being paid at the moment. The idea is to try to increase that up to (state average cost) \$18 or \$19 a day for indigent patients, and they think that would bring the total private patient cost down. In other words, at the present time it is the feeling that the people who pay their own care are taking care of a portion of the indigent patients, and the whole idea behind Dr. Stanford's program is to bring that indigent payment up so as to take care of the total hospital cost.

Some counties already supplement the pool fund payment from the state of \$10 per day and take care of the differential in the reimbursable cost in individual hospitals. Dr. Stanford has worked on this diligently. The subcommittee recommended that this be passed on to the July Conference and recommended that we as a Medical Society back this for General Assembly action next year.

DR. BEDDINGFIELD: One thing about that, Mr. President. When this came out in the newspapers a few months ago, several newspapers ran an article wondering if the hospitals and the doctors weren't getting rich off this \$10 a day, because they don't know what it cost per patient per day.

DR. SAMS: Dr. Kernodle, do you know how much increase that would be from the State appropriation setup?

DR. KERNODLE: Dr. Stanford and Dr. Ellen Winston worked this thing out and said it would be about half a million dollars. I think they are a little low on the figure. I think they would have to put up about a million dollars to take this whole cost statewide.

SECRETARY RHODES: I should like to say that I think Dr. Kernodle's figure is conservative, because I happen to know one hospital in this county that had over \$100,000 involved in this very thing last year, so that is a conservative estimate of a million dollars for the state, I would say.

DR. KERNODLE: Of course, John, if you say a million dollars from the state, you get a million dollars from the county, and then you get four million dollars from the Federal Government, which is unused money as far as our use of this particular program is concerned.

DR. A. JOHNSON: Not only unused money, but exacted from the taxpayers of North Carolina to be up there unused.

DR. KERNODLE: The recommendations from the Subcommittee on Prepayment of the Aging as well as Indigent Care in this program was that we take it all (increase to reimbursable level) now and get to the basis of it and swallow this whole thing in one term, rather than taking a little in per diem increases every biennium.

I think that action should be taken to endorse this particular part of the program. We have endorsed on each occasion during the last four years that there be an increase. Last year we endorsed that it be increased to \$10.50.

PRESIDENT REECE: Do you wish us to make a motion?

DR. KERNODLE: I do.

[Motion was duly made.]

DR. NORFLEET: I second it.

[The motion was put to a vote and carried.]

DR. KERNODLE: Committee on Maternal Health, they have been doing an excellent job, and I have a letter of communication from Dr. Lafe Ludwig (chairman of AMA Council on Medical Service) which comes under item 10 (d), and I would like to read to you a paragraph in which Dr. Ludwig had written to Mr. Barnes and asked that this letter be taken up before the Council.

I know you are familiar with the structure of the Council on Medical Service which has seven committees working on various phases in the medical service area. At a recent meeting the Council discussed the possibility that sometimes physicians serve on these national committees and devote a great deal of time and energy in working for the profession without our having apprised the state society of their contributions.

In view of the foregoing, the Council on Medical Service would like to call the attention of the officers of the Medical Society of the State of North Carolina and,

if deemed appropriate, your House of Delegates, to the service Dr. James F. Donnelly, Jr. is giving to the profession through his work on the Committee on Maternal and Child Care. Although Dr. Donnelly has only been a member of the Committee since May, 1959, he assisted the Committee in its work even before his appointment. The Committee is currently working on "A Guide for the Study of Perinatal Mortality and Morbidity." This effort has received favorable comment in the United States and in foreign countries.

I know you are aware that A.M.A. Councils and committees must rely largely on the gratuitous service of physicians, such as Dr. Donnelly. Medicine can be proud of these physicians, and it is our hope that during your forthcoming annual meeting the Council's sincere expression of appreciation of Dr. Donnelly's contributions can be relayed to the officers and members of the Medical Society of North Carolina.

I suggest a motion that the Executive Council write a letter to Dr. Donnelly similar to the letter being written by the President to Dr. Mark Lindsay in appreciation of his action.

[Motion was duly made.]

[The motion was duly seconded by Dr. Beddingfield.]

[The question being called for, it was put to a vote and carried.]

DR. KERNODLE: The next Committee I would like to point out is the Committee on Occupational Health, and merely to reiterate the fact that there is to be an AMA Conference on Industrial Health in Charlotte October 10th to 12th, 1960, and invitations to attend and participate are extended. They want to get that before the House of Delegates again for endorsement.

The Committee on Veterans' Affairs, the Chairman of this Committee reveals that there is a new contract that is not referred to in the report has been signed and sealed equivalent to last year and will take effect July 1, 1960.

Secondly, he also recommended that there be two or three members of this Committee appointed to work closely with the Chairman, with the Veterans Administration and Intermediary Service.

He thinks that the Committee is too large and would like to boil it down into a smaller group. It is our feeling that Dr. Elfmon be brought into this, and I suggest we accept his recommendation.

[Motion was made.]

[The motion was duly seconded, put to a vote and carried.]

DR. KERNODLE: I mentioned a minute

ago that we were attempting to get as many physicians recognized by our Governor and recognized on the White House Conference Program as possible. It is a difficult thing to get to the Governor since the Commission that was appointed is now in direct charge of the overall White House Conference Program for the State. This Commission was appointed in 1954.

We have one member in this audience on that Commission, Dr. Norton, but we as doctors have been very fortunate in getting members on the subcommittees of the advisory group, and Dr. Ellen Winston, who is Chairman of the Commission, tells me that she is going to try to get a rounded delegate representation. We want you, if you have any personal relationship to Dr. Winston, or the Governor, to get some action and stimulate our representation on this group of 48 delegates to the White House Conference on Aging in January 1961.

DR. KERNOLDE: That completes my report.

PRESIDENT REECE: Thank you, sir.

DR. BENTON: He just spent \$500; Amos Johnson just spent four or five hundred dollars that is not in the budget for this year. Would it be asking too much to let it be the policy of the Board when you spend money that is not budgeted that it be understood and the Chairman recognize that that will not be available until next year, except in the case of a dire emergency?

So when you spend money like that, would it be asking too much to let it be understood that that is effective January 1st, not this year, because it is not in the budget?

PRESIDENT REECE: It was my assumption that these had been cleared with your Committee before these requests were made. I may have been wrong with that.

MR. BARNES: I think, Mr. Chairman, that Dr. Benton makes a good point, that it has always been the practice in the Medical Society, if a thing is to come up and it is important enough to make these extra appropriations from time to time, and it leaves you administratively with the burden of making the cloth meet—I think he has a good point, that if it is a dire emergency, then the Finance Committee ought to see that it is taken care of, but if it is not, it ought to go into another year's budget.

PRESIDENT REECE: I think if we proceed here, we can get through very shortly after one o'clock, if not at that time.

At this time, we are through Commission Reports and we are down to the annual reports of committees. There are quite a few of those that we may not even have to take up. I would like to make this state-

ment, in continuing my policy of inviting members to the Executive Council, our delegates to the AMA have been invited again Dr. Strosnider, Dr. Hill, and also Dr. Faison to be with us yesterday and today. We are glad to have them here.

I think this is an important function of the Society and one that should be fostered, and it will be one of my recommendations to the House of Delegates that at least our delegates to the AMA should attend the Executive Council of the State Medical Society to be available for deliberation and discussion of our local problems, and as they may relate to the AMA up and down.

At this time, I would like to recognize one of you gentlemen, if you have any comments to make, or reports you would like to give us. If not, we are glad to have you with us, and we hope you will enter into our discussion and deliberations.

DR. STROSNIDER: I feel that it would be wise for your delegates to the AMA to attend the meetings of the Council because you have problems coming up here, and when these problems come up we have resolutions on all subjects in and out of the profession, and I feel if we had the information and the guidance of our Council and knew what problems we had, when those resolutions were presented to the House, we could follow those resolutions through going to the respective reference committees and be better informed to represent our State than we are at the present time. That is the suggestion I have to make.

DR. HILL: He is speaking for us.

PRESIDENT REECE: Thank you, sir.

Under item 9, if there are any committee reports that need to be taken up in detail, or anyone has anything that did not go into the compilation, this is the time to present it.

MR. BARNES: Mr. Chairman, if you will notice in the listing of these committees, there is an "S" by certain ones which means that there is some substance that is related to that committee report that was not contained in the report, and maybe you would like to have those considered; I don't know.

PRESIDENT REECE: Do you mean on Child Health?

MR. BARNES: For instance, on Child Health, the item was the budget which you have already taken care of.

PRESIDENT REECE: Scientific Exhibits, on Page 3.

MR. BARNES: I simply wanted to call attention of the Council that at the last meeting there was some discussion of permitting the North Carolina Dairy Council to exhibit as a scientific exhibitor, and there was no action taken on it, and later you

instructed me to round-robin the members of the Executive Council for a vote as to how they regarded that exhibit.

I think with one or two exceptions, the vote was no, to support the Scientific Exhibits Committee in declining the space. I just noted here last April 16th, after this vote was taken, that the Committee on Scientific Exhibits has accepted an exhibit from the North Carolina Dairy Council. So I wanted you to know that I carried out your request and got the vote, and despite that the Committee acted differently.

SECRETARY RHODES: Weren't there two questions to the Councilors about that, tobacco and dairy? Personally, I thought there was quite a difference in those two.

MR. BARNES: Some though that and voted differently.

Under Arrangements, I made a report that the City of Asheville has confirmed that we have May 6th through 10th in 1961, and May 4th through 8th in 1963, if we want to go back there to meet, at the auditorium, and the hotel facilities in the city. We have arranged that on the basis of the recommendations of the Nominating Committee.

I have a communication letter dated April 22nd written to Dr. McMillian as Chairman of the Committee Advisory to the Auxiliary. He has pinned a note to it addressed to me.

It is going to involve a recommendation for some increased funds for the Auxiliary, perhaps for another year, in reference to their organization employing at least a part-time paid executive worker.

PRESIDENT REECE: Let his committee study it and let us know what they recommend. Ask him to study it and make a recommendation to us.

MR. BARNES: This is a letter from Dr. Charles Styron, and a carbon copy of a letter from Dr. Raney, Commissioner on Annual Convention, in which they recommend expenditures of \$200 for the Golf Committee. I am sure this is mostly in prizes which we have obtained from our insurance and exhibitor friends, and I don't believe that this actually is going to be required, but this is a formal request for a \$200 appropriation for the Golf Program this year.

DR. GARRISON: I think a little bit of that is to pay a pro or somebody to be totally responsible for conducting the tournament. I don't know about the prizes.

MR. BARNES: We have a complement of ten prizes which will run in the neighborhood of \$200.

DR. GARRISON: But it is impossible to have a member out there in charge all day Monday and all day Tuesday. Some are going in the morning and some are going

in the afternoon, and they go at different times. They have had some difficulty in getting the scores posted and getting their cards in, and end up that they weren't even counted.

MR. BARNES: I would think we ought to go along with whatever the Committee needs in the way of accommodations for the tournament.

DR. PASCHAL: Mr. Chairman, could we not provide these funds on a contingency basis, that if they are needed they will be furnished. If they aren't they will just revert back to the Association.

[At this point Dr. Kitchin assumed the Chair.]

CHAIRMAN KITCHIN: Would you put that in the form of a motion?

DR. PASCHAL: It would answer Charlie's problem, and he would have these funds available if he needs them, and he would know that he would have them. I make a motion to that effect.

[The motion was duly seconded, put to a vote and carried.]

CHAIRMAN KITCHIN: The next question is that of Medicare.

Now under the report of the Committee on Armed Forces, Medicare, I think what he intended was to confirm that there had been a new contract negotiated the 18th of April.

MR. BARNES: A letter from Dr. Ravenel's Committee on Polio.

DR. NORTON: I think it would be a good idea for the duties of the Committee—and probably use this same committee without changing the name necessarily—that they might also study and advise on other immunizations.

CHAIRMAN KITCHIN: I wonder if it would be a good idea to have a motion along that line, so no one would think this committee was overstepping its bounds.

DR. BRIDGER: I made that as a motion as he stated it.

CHAIRMAN KITCHIN: That the scope of the Poliomyelitis Committee be enlarged to include other immunizations as they deem proper. Is there any discussion of that?

DR. THOMAS MURPHY: How about adults? In his report here he is referring particularly to adults. On Page 102 here, he has reference particularly to diphtheria and tetanus in adults.

DR. BEDDINGFIELD: Mr. Chairman, I would like to offer an amendment to the motion and suggest to Dr. Ravenel that he maintain liaison with these other committees, and that there be no overlapping of functions. If he is going to maintain liaison

that is fine; if he is going to overlap, that is not fine.

[The amendment was accepted.]

[The motion was duly seconded.]

CHAIRMAN KITCHIN: Are you ready to vote on the amended motion? All in favor let it be known by saying "aye"; all opposed? Carried.

MR. BARNES: I have one further item, a letter from the Committee on Rural Health, Dr. Hugh A. Matthews, and he has two matters that he wants the Council to determine some policy on:

The first concerns the recommendation of the State Rural Health and Education Committee that the Executive Council consider new ways and means of selecting the General Practitioner of the Year. The Committee felt that under the present system the merit of the presenter carried more weight than the record or brochure of the physician presented. Belief was expressed that the House of Delegates took the task of selection more as a boring chore than an opportunity. Suggestion was made that a score card be prepared possibly with the assistance of the North Carolina Chapter of the American Academy of General Practice, for committee use in selection of the three leading candidates and that the Executive Council consider final selection and then presentation of the winner to the House of Delegates. This I was requested to submit for consideration and possible future action.

Do you want the other one read, or do you want to act on them one at a time?

CHAIRMAN KITCHIN: Let's take them one at a time.

DR. BAKER: I move that the Council go on record as approving this suggestion.

[The motion was duly seconded by Dr. Sams.]

CHAIRMAN KITCHIN: Is there any discussion of that motion? If not, all in favor let it be known by saying "aye"; opposed by a like sign. Carried.

MR. BARNES: The second one is:

On July, 1960, the North Carolina Rural Safety Council will become an official organization of the State, Constitution and By-Laws of which are available at the State Office of the Medical Society. This safety council formation was initiated by the Rural Health and Education Committee and with the request of its Advisory Committee and with the sanction of the Executive Council.

The Rural Health and Education Committee now requests the Executive Council to give authorization for the Medical Society of the State of North Carolina

to become a member organization of the North Carolina Rural Safety Council with all privileges and obligations of membership. When and if invited to join the safety council, Section VI of the By-Laws reads: "An organization, agency or active voting member will be assessed a minimum of \$15.00 per year upon affiliation."

What he has recommended here is membership in the North Carolina Rural Safety Council at a minimum membership charge of \$15.00 per year.

CHAIRMAN KITCHIN: Does anyone here have any knowledge of that or wish to discuss it in any way?

DR. AMOS JOHNSON: I would make a motion that this recommendation be approved. I am cognizant of it. I think it would be a poor maneuver to stay out of it for \$15.00, and I move that we approve it.

[The motion was duly seconded by Dr. Koonce.]

CHAIRMAN KITCHIN: Is there any discussion?

[The motion was put to a vote and carried.]

The next thing on the agenda, John, is to consider a resolution on Dr. Moir S. Martin for the House of Delegates. Would you carry it on from here?

[President Reece resumed the Chair.]

MR. BARNES: This resolution was drafted last January. I will read what we have into the record.

Whereas, Our Heavenly Father has seen fit to call Home our beloved friend and co-worker Dr. Moir S. Martin, the North Carolina Board of Nurse Registration and Nursing Education desires to record its deep sorrow at the passing of Dr. Moir S. Martin on January 4, 1960, who was a member of this Board for 22 years, therefore be it

RESOLVED, That the North Carolina Board of Nurse Registration and Nursing Education and the North Carolina Board of Nurse Registration and Nursing Education Enlarged and Counsel hereby give formal expression of their grievous loss in this death and do note the passing from this life of our friend who was esteemed by his associates, loved by his friends, respected by all and was ever ready to advance the usefulness of the Boards by material contributions as well as by wise counsel and enthusiasm for the work.

DR. GARRISON: I so move.

[The motion was duly seconded.]

MR. BARNES: I think really what we had on here was whether or not on a pro-

posed resolution it should be presented for adoption in the House of Delegates like we ordinarily do when some outstanding member of the Society passes.

Here is a form of a resolution, if you want it presented in the House, that could be presented and acted upon in the House.

Whereas, This House of Delegates has experienced the long and useful services of Dr. Moir S. Martin as delegate from Surry County and as committeeman and leader in the affairs of this Society, and

Whereas, By election of this House of Delegates, and then by appointment by the Chief Executive of the State, Dr. Moir S. Martin served notable and useful years upon the North Carolina Board of Nurse Examiners and later on the North Carolina Board of Nurse Education and Nurse Registration, and

Whereas, His services to this Society have been characterized by the same sacrifice and devotion to duty and obligation as manifest in his long and useful practice with patients in the Mount Airy community,

THEREFORE BE IT RESOLVED, That this House of Delegates express for posterity and particularly to the Surry County Medical Society and his family the sense of great loss to this Society in the death of Dr. Moir S. Martin during January 1960, and be it further

RESOLVED, That the record of this resolution be spread upon the proceedings of this House of Delegates and that copies be sent to the Surry County Medical Society and to Mrs. Moir S. Martin of Mount Airy.

DR. SAMS: I move it be presented to the House of Delegates.

[The motion was duly seconded put to a vote and carried.]

PRESIDENT REECE: American Registry for Doctors' Nurses.

MR. BARNES: This is a communication dated April 9, 1960, from the American Association of Doctors' Nurses, addressed to the North Carolina Medical Journal:

Dear Editor:

I am enclosing a news release which will be of special interest to your doctor members and their nurses.

We will appreciate any use you can make of this item and would appreciate a copy of your publication.

This, of course, was addressed to us because they want this material run in the Journal, and they want to gain a free subscription to the North Carolina Medical Journal.

As business manager, knowing that the AMA looked with disdain upon this organi-

zation. I did not want to accede to this request, but I felt like I had better let you all know the problem before us.

DR. BEDDINGFIELD: Right along that same line, we have another communication from the American Association of Medical Assistants, and this organization has an entirely different request: in fact, the AMA has passed a resolution commending the objectives of the American Association of Medical Assistant.

In their Constitution and By-Laws, they maintain that they are non-union: "This Association is hereby declared to be non-profit. It is not nor shall ever become a trade union or collective bargaining agency." This is simply an association of doctors' assistants, secretaries, nurses, receptionists, aids, what have you; it is an educational thing. I think this is the organization that we should push, that has been endorsed by the American Medical Association, and now does not have any relationship at all with this organization (American Registry for Doctors' Nurses) that made an approach to the Journal.

This came to the Public Relations Committee with a request that we disseminate their literature to physician members, and knowing that there was some reluctance on the part of the Council to approve any of these nurses' aid associations, I think that this is the most benign one, and if we get this one in, it will probably keep the others out, and I think we ought to endorse and disseminate information for this one, the American Association of Medical Assistants, because it has been endorsed by the AMA and it can help us and not hurt us.

DR. SAMS: With the first one, I move we follow the directions of the AMA and reject the first one that Mr. Barnes read.

[The motion was duly seconded by Dr. Norfleet.]

[The motion was put to a vote and carried.]

DR. SAMS: Now, Mr. President, I move that we accept the one that has been endorsed by the AMA and presented by Dr. Beddingfield.

[The motion was duly seconded by Dr. Beddingfield.]

PRESIDENT REECE: The motion has been made that we accept this Medical Assistants advertising.

[The motion was put to a vote and carried.]

MR. BARNES: I have from the Wake County Tax Supervisor a schedule here in which it says that "The market values in this schedule are based upon today's reproduction costs less depreciation, and not necessarily on the price you paid. We do not recognize accelerated depreciation rates,

nor do we allow full depreciation on any item still usable regardless of age."

This schedule is in reference to the personal properties or chattel properties of the State Medical Society in the headquarters office, and sometime ago, I think your audit report will show that those were acquired at an accrued cost over a period of some 30 years, at about \$40,000. We went over the material in the office some time ago and we recommended to the tax assessing authorities a schedule involving about \$6,-403.50.

Now they apparently have established this rate of \$3,566 and I would say that it is in our favor, and that we ought to accept this assessment of value for tax purposes on our property.

SECRETARY RHODES: I believe that is established at 35 per cent of the value of the property, is that right?

MR. BARNES: Somebody has told me it was 35 per cent.

DR. BRIDGER: I move it be accepted. [The motion was duly seconded by Dr. Sams, put to a vote and carried.]

MR. BARNES: I simply wanted to call attention to the fact, particularly anybody from Mecklenburg County, to this article that was by-lined by Don Seaver in the *Charlotte Observer* on April 24th, in reference to Physician Placement Service of the State Medical Society.

I thought it was factual except in one little paragraph he sort of expanded it beyond what we said; but I just wanted you to be aware that he had checked the facts with us before he wrote this article, and we hope nobody found any objection to it.

PRESIDENT REECE: Old business.
MR. BARNES: Do you know when Dr. Caldwell is going to report on his trust.

DR. BENTON: He is going to report to the House of Delegates. He is going to be here at two o'clock. He is not here now.

PRESIDENT REECE: Delegates to the U. S. Pharmacopoeial Convention.

DR. BEDDINGFIELD: Mr. President, I have a report; it is noncontroversial. I see no need to read it, and unless you want me to, I will submit it as a matter of information.

I went to their convention on March 29 and 30 in Washington, D. C. I think it is important that we be represented at this every ten years.

The Executive Council on May 2, 1959, designated the undersigned as the official delegate of the Medical Society of the State of North Carolina to the Decennial meeting of the United States Pharmacopoeial Convention, held in Washington, D.C. on March 28, 29 and 30, 1960. Your delegate attended all sessions of the con-

vention. This convention is the governing body of the United States Pharmacopoeia, or USP. The convention meets every ten years and has done so without interruption since the inception of the USP in 1820. The Constitution and By-Laws stipulate that every state medical society, every state pharmaceutical society, every school of medicine, every school of pharmacy, certain departments of the Federal Government, and certain associates of drug manufacturers shall all be entitled to one delegate at the convention. Thus, there are 277 organizations entitled to send one delegate. Approximately 250 delegates were present.

The USP convention has its primary function the publishing of the Pharmacopoeia, which sets forth standards of purity, strength, and potency for the accepted medications now in popular use. The 16th revision of the USP has just been published, containing 989 drugs, of which 306 are new additions; 159 drugs were removed from the USP.

Content of the USP from revision to revision is accomplished by the Committee on Revision, whose members are elected by the convention.

It is of interest to note that the USP, although published by a private corporation, enjoys quasi-legal status inasmuch as by law it is recognized as the legal standard for drugs in federal law, in most of the state laws, and in a great many foreign countries.

The USP a century ago was a compilation of formulae and remedies frequently referred to as a matter of necessity by practicing physicians. Because of changing practices and the development of modern-day pharmaceutical industry, physicians now very infrequently refer to this work, and some are perhaps unaware of its existence.

The physician does not use the book, but he uses what it means. He can practice medicine securely because of it. He can practice securely because he has confidence that somebody is looking after the standards of purity and all the other standards of the drugs he uses. If he has thought about it he realizes that other reference books rest largely on the strength of the USP and NF behind them. In fact, in all his textbooks, journal articles and even commercial presentations, they have the ultimate zeromile of the USP from which to start their excursions.

The physician also knows, though probably equally subliminally, that USP drugs are likely to be effective and safe, and he

cannot help but compare new drugs with those bearing the designation. Automatically, acceptance by the USP then means to him that a drug is of assured purity and that it is held by the relevant experts to be useful and safe.

I recommend that this Society be again represented at the next USP convention in 1970.

DR. SAMS: I move we accept the report. [The motion was duly seconded, put to a vote and carried.]

MR. BARNES: Under (b) I would say that all committee chairmen, commissioners, members of the Council and officers of the State Medical Society usually attend the exhibitors' party which will be given tomorrow evening at the Carolina Hotel at, I believe, five-thirty.

It is a sort of little social hour with heavy hors d'oeuvres and some entertainment, and the exhibitors have come to look upon this thing as a very fine favor of the State Medical Society, and if you folks can go around and attend this thing tomorrow afternoon from five-thirty until about seven, you should do so.

If, I may, Mr. Chairman, I have a new item of business under new business. I have a letter from Dr. Clyde Ward, President of the Wake County Medical Society.

There has been a death in one of the Raleigh children's nurseries recently which I understand was overcrowded, unlicensed and poorly supervised.

In a conversation with Mrs. Josephine Kirk and Dr. Isa C. Grant, I was informed that North Carolina has no law by which they can enforce the standards prescribed by the Welfare Department.

I believe that this is a situation which should be taken up with the State Medical Society to see if something can be done to enforce certain standards and rules concerning child nurseries in North Carolina.

Very truly yours,

W. Clyde Ward, M.D., President
Wake County Medical Society

DR. PASCHAL: Mr. Chairman, this happened here in Raleigh, and it was in the press. I didn't see it. I was out of town at the time this appeared. However, it caused considerable comment. I think that it would be well for us collectively, as an organization, to foster such legislation that might remedy this situation. Just to which committee it might be referred I do not know.

I make the motion that it be referred to the appropriate committee for their study, and their recommendation, and that the fact that it has been referred be given adequate publicity.

[The motion was seconded by Dr. Squires.]

PRESIDENT REECE: The motion made and seconded is that this be referred to the appropriate committee. We will have to decide whether that is the Child Health Committee or something else. We don't have a committee on nurseries, do we?

DR. SAMS: If we need legislation on that thing, it ought to go eventually to the Legislation Committee.

[The motion was put to a vote and carried.]

MR. BARNES: There is this one final item, a letter from Dr. Charles Styron dated May 3rd.

On Wednesday, April 27th, about twenty-five representatives of professional and public-spirited organizations met at the College Inn, Raleigh, North Carolina. The purposes of the meeting was to form a North Carolina Council on Food and Nutrition. This council had been proposed by leaders in nutrition in North Carolina and was the outgrowth of an inter-association committee, composed of delegated members of three professional organizations, namely, the North Carolina Home Economics Association, the North Carolina Dietetic Association, and the Nutrition Section of the North Carolina Public Health Association.

The purposes of such a council shall be to provide an opportunity for agents, disciplines and organizations interested in food and nutrition to exchange ideas and information, to coordinate programs promoting improved nutrition, and to augment the efforts of other organizations in disseminating nutrition information to the general public.

At this meeting, temporary officers of such a council were appointed, and plans were made to construct a constitution and set of by-laws. It is the purpose of this organization, furthermore, to invite acceptable organizations interested in food and nutrition to send a representative to participate in the future activities of such a council.

It seems to me that this is a very worthy cause, is made up of excellent personnel, and should be supported by the State Medical Society. Any cost would be nominal. I suggest such participation.

Sincerely yours,

Charles W. Styron, M.D.

I think he was designated by you, Dr. Reece, to attend this thing on a request from some leadership in the Agricultural Extension Department that was considering the organization of this Council. That is the recommendation.

DR. AMOS JOHNSON: I move it be accepted.

[The motion was duly seconded, put to a vote and carried.]

PRESIDENT REECE: That completes all we have here.

Dr. Rhodes has something, I believe.

SECRETARY RHODES: Mr. President and members of the Council: If you will recall at the January meeting at Pinehurst, I brought to you a request from the Director of the District Office of Social Security here in Wake County regarding the possibility of utilizing physicians to train their office personnel, particularly those people whose duty it was to act as a sort of clearing house for people applying for disability; and if you will recall, the Council approved this in principle, but directed us to seek further information from other areas, and so we have done that.

We have contacted the Medical Societies of all the Southern states and have had returns from nine of them, and in all instances with one exception, there had been no contact between the Medical Society and Social Security agencies in their areas. In fact, one or two expressed some objection to such contacts.

The exception was in Tennessee, where the President of the State Medical Society appoints a single man to act as a liaison with the Social Security organization.

Now we have taken no further action on this matter, because I thought that perhaps I should bring that information back to this Council, and then be guided by your instructions as to how I should further pursue this.

DR. BEDDINGFIELD: Along this line, you remember the book they had entitled "Common Medical Impairments."

SECRETARY RHODES: I had a copy of it, I believe, at the meeting.

DR. BEDDINGFIELD: I was interested in this, and I tried to get a copy of this book from the Social Security people. I was turned down, and I tried my Congressman, and my Senator, and they tried to get copies from Social Security, and were told that this information could not be released.

SECRETARY RHODES: I still have the book. I haven't returned it.

DR. BEDDINGFIELD: I wonder how that came to be classified information, but you cannot get a copy of it.

DR. AMOS JOHNSON: What do you recommend?

SECRETARY RHODES: My thinking about the matter is this: that I believe this is an area here for liaison with these people, because we are going to be faced, I am sure, more and more with the necessity for some sort of cooperation. I do not clearly now see

how we could undertake to train personnel in their offices. I don't believe we have facilities for it. It seems to me if we decided to do it, it would have to be done on a local level, that is, the instructors would have to be supplied by members of local county societies in the areas where these offices are located. There may be a possibility to set up a program of that sort, but it doesn't seem to me that we could expect to establish within the minds of these lay people too much in the way of actual ability to determine disability in their applicants and they still would have to be cleared on the basis of reports from their local physicians, and on the basis of review by a medical board.

Now they do have a board which does review these people which does contain physician members.

I think the state society on the state level could possibly have some sort of liaison between one of its committees and Social Security. I don't know which committee that would be. I haven't thought about that. But I do believe there is an area there where we might establish a liaison.

DR. AMOS JOHNSON: In how many locations in North Carolina would that be?

SECRETARY RHODES: They have four-teen district offices in North Carolina.

DR. JOHNSON: And they wanted to train personnel in each of these?

SECRETARY RHODES: That was the idea.

DR. JOHNSON: Would it be feasible to have the Medical Society of the area involved, the County Medical Society of the area involved, appoint one man to act as liaison?

SECRETARY RHODES: I think if we do anything, we would have to do it on the basis of the local level, I mean so far as any direct contact between these various district offices and the medical profession is concerned. It seems to me that would have to come from the local society in the area where the district office is located. I think there might be some ground for study along that line, or liaison certainly.

DR. THOMAS MURPHY: It would be useful to have contact on the state level so we know what is going on all over.

SECRETARY RHODES: I mean any progress which would involve instruction of personnel would have to come from the local level. Personally, I think it would be better to set up a state level liaison first and then maybe from whatever committee handles that some sort of plan could be worked out.

DR. AMOS JOHNSON: You make a motion that a liaison on a state level be set up?

SECRETARY RHODES: Yes. It could be done through one of their committees probably. I would think that was something we

could do, and I would make such a motion.

[The motion was duly seconded, put to a vote and carried.]

DR. PASCHAL: President Reece, I have one brief item to ask you to consider under new business, and it has to do with the filing of the Constitution and By-Laws of the various county societies, or the various component county societies.

Recently here in Wake County, the Constitution and By-Laws have been misplaced, and the officers of the Society did not have them available. I understand that some are filed at state headquarters, and that in times past an effort has been made to get a copy of all of these to be sent in to headquarters on file. I think it would be of some advantage both to local societies and to the state organization as a whole to have the same requirement, that copies of individual Constitution and By-Laws be filed at state headquarters, where they could be kept, say, in a repository, and the amendments as they came in would have to be submitted as well.

I think that would probably involve a change in our Constitution and By-Laws on the state level, and I would ask consideration of this Council in fostering such a program, and to that end I move that this matter be referred to the Committee on Constitution and By-Laws, with the request that they consider changing it to make this a requirement of the various county societies and the various component county societies. I make such a motion.

[The motion was duly seconded by Dr. Williams.]

PRESIDENT REECE: All in favor say "aye"; opposed "no." It's carried.

MR. BARNES: Gentlemen, Dr. Reece has requested I present here three telegrams inviting us to meet in Durham in 1961 or 1962. Of course, the Committee on Nomination has already recommended meeting places for 1961 and 1962 and 1963.

DR. AMOS JOHNSON: I would think these things would be referred to the Nominations Committee.

I make a motion that this be referred to the Nominations Committee and that they evaluate, give thought to evaluating these places as a possible place for future conventions.

[The motion was duly seconded, put to a vote and carried.]

PRESIDENT REECE: That's all we have, Mr. Barnes?

MR. BARNES: That's all.

PRESIDENT REECE: Thank you very much. Do we hear a motion to adjourn?

[Upon motion regularly made and duly seconded, it was voted to adjourn at one-twenty o'clock.]

MEETINGS OF THE HOUSE OF DELEGATES

MONDAY MORNING FIRST SESSION

May 9, 1960

The first session of the House of Delegates held in connection with the One Hundred and Sixth Annual Session of the Medical Society of the State of North Carolina convened in the Reynolds Coliseum, Raleigh, North Carolina at ten o'clock, the meeting being called to order by the President, Dr. John C. Reece.

PRESIDENT REECE: Will the delegates please take their seats. If any have not checked in at the desk, please go by and do so.

This session, representing the One Hundred and Sixth Annual Session of the Medical Society of the State of North Carolina is now convened, this representing the first meeting of the House of Delegates.

We will open with the Invocation. I would like to present at this time the Reverend Thomas J. Youngblood, Jr., Pastor of the Hillyer Memorial Christian Church of Raleigh.

THE REVEREND THOMAS J. YOUNGBLOOD, JR.: O, Thou Creator and sustainer of life, who hast called these men and women to be coworkers with Thee in this divine activity, we beseech Thee to bless the members of the medical profession here assembled and all others who have dedicated their lives to the relief of suffering and the conquest of disease. Guide them as they search for greater understanding of Thy creation and as they give themselves in the service of mankind.

Grant, O God, that the meeting of this Society will increase the skill and proficiency of those who are here and give new significance to the work which each doctor performs.

Grant, our Father, that these who spend their energies so freely for others may find their own mental, physical and spiritual resources replenished as they meet together in sessions of the convention.

In the spirit of the Great Physician, we offer our prayers. Amen.

PRESIDENT REECE: I will recognize Dr. John Rhodes, Secretary of the Society, for announcements.

SECRETARY RHODES: President Reece, Guests and Members of the House of Delegates: We hope that you will find here in Raleigh a facile and a pleasant place to meet. We are proud of our facilities, and we have done everything we know how to do to make your stay here a pleasant one. If prob-

lems develop we will be glad to try to help to solve them.

[Dr. Rhodes then made various announcements of passing interest.]

PRESIDENT REECE: At this time, I will present to you the Speaker of the House of Delegates, Dr. Donald Koonce.

SPEAKER KOONCE: Ladies and gentlemen we will proceed with some of the parts of the agenda until the quorum is declared.

I would like again to call on Dr. Rhodes to introduce our honored guest, the Mayor of Raleigh.

SECRETARY RHODES: Gentlemen, it is a real pleasure to present to you our esteemed Mayor of Raleigh, my friend, who has no peer as a Mayor, Mayor Bill Enloe. [Applause]

THE HONORABLE W. G. ENLOE: Thank you, John. Mr. President, Distinguished Guests, Ladies and Gentlemen: I think my purpose here is to try to stall and to fill in time until you get a quorum, but I am not going to talk that long.

It is always a pleasure and a privilege to welcome a convention to Raleigh, but to be able to welcome the House of Delegates of the Medical Society of the State of North Carolina during your annual convention is an honor I shall long remember.

Ladies and gentlemen, just let me tell you how pleased we are to have you here in Raleigh. If there is anything we can do to help make your convention more successful, please let Dr. John Rhodes or some of us know, and we certainly will try to do so. We are so glad to have you, hope you will hurry back, and that you will have not only a successful, but a most enjoyable convention.

SPEAKER KOONCE: Now the chair is going to use its prerogative, and a very pleasant one to me, and that is to recognize our immediate past speaker of the house, Dr. Westbrook Murphy, and have him come up and say a few words. [Applause]

DR. MURPHY: Mr. Speaker, ladies and gentlemen, I assure you that that was entirely unexpected. I knew, as I just told Ted Raiford, that I was such an old war horse that I had butterflies in my stomach although I had no responsibilities whatsoever. Perhaps that was a premonition.

I am truly overwhelmed to be in this Coliseum building and by this occasion.

It is a real privilege to be back to see you again. It was very kind of the speaker to give me this unexpected privilege. I do say he might have given me a few minutes' notice so I could prepare a speech for you.

But he felt impelled to call on me, I should say, for two reasons. During my years as President and as Speaker of the House, I brought no great talents, no great gifts to that position, but such success as I may have had came because of one virtue, faithfulness.

And so to the young men who must inherit the mantle of the present generation, I hold that out as the greatest virtue of all, faithfulness.

The other reason that he felt impelled to give me this privilege no doubt is because he knew that I have loved you all.

I would say to you that you should now undertake to find a worthy successor to Grady Dixon. Grady used to sit right there, and, with a rather sardonic twinkle in his eye, wait for me to make a mistake, and I always did and he always caught it.

It seems to me that I remember a young man from Onslow—I don't remember his name for the moment, but I offer him as a possible successor. Anyhow, there should be a Grady Dixon sitting right there to look the Speaker of the House in the eye. It certainly greases the wheels, I can tell you that.

I am sure that Dr. Koonce thinks that I have taken up enough of your time.

One last word—don't put me on the shelf entirely. I will always love this Society. Perhaps there may be some small thing that I can do. If so, it will be a privilege.

[The audience arose and applauded.]

SPEAKER KOONCE: I don't think I can tell you how I feel about Dr. Murphy. I think you know. It certainly gives me a sense of gratification to know that he is in the audience so that if I do make a mistake—since Grady Dixon's successor is not here—I can call on him for advice.

We have two distinguished guests who will be on our program this afternoon, and I don't know whether they are here or not. They are Dr. Leonard W. Larson, Chairman of the American Medical Association Board of Trustees. Dr. Larson is not here. Another is Dr. Donald H. Stubbs, Chairman of the National Blue Shield. Dr. Stubbs, we are very glad to have you with us. [Applause]

The next thing on our agenda is the appointment of a Parliamentarian. I would like to ask Dr. George Paschal if he will serve in that capacity.

Next is the appointment of a Reference Committee on Resolutions. If you remember, by your By-Laws, the most recent ones, the resolutions will be presented to the House today, they will go to the Committee on Resolutions, and be brought back with a report tomorrow afternoon. On that committee I would like to appoint our Secretary,

Dr. John Rhodes, as Chairman; Dr. Shuford and Dr. Paschal.

Next is a Reference Committee on the President's and Officers' reports. On that I would like to ask Dr. Pete Schoenheit if he would serve as Chairman, Dr. Nichols of Morganton, and Dr. Wingate Johnson. As we go along, I will try to make a few remarks to keep us on schedule. We will have to deviate from the agenda in one or two instances, but we will try to follow it as much as possible.

The next thing on our agenda is the message of the President, Dr. John Reece. [Applause]

PRESIDENT REECE: Mr. Speaker, and Members of the House of Delegates, Ladies and Gentlemen: At this time it is customary for the President of the Medical Society of the State of North Carolina to report to you on the activities of the Society during the past twelve months.

When I became President last May, I closed my presidential address with the statement, "May we unite our efforts in the interest of organized medicine, and during the coming year together we will learn that it is a joy in life to find, at every turning of the road, the strong arm of a colleague kind to help us onward with our load."

During the past year I have found my closing words then to be true, for it has truly been a joy to serve in the capacity of President, and the honor I have had during this year is one I shall always treasure and hold in highest esteem. Throughout the year, at every turn, I have felt the strong arms of many faithful and capable colleagues who have served so willingly and conscientiously in each position they hold, as officers of the Society, as members of the Executive Council, as Committee Chairmen and Committee Members. To thank each one of you by name would take too much of our valuable time, but I would like to express my deep appreciation to all of you who have served with me and have so faithfully and diligently carried out the program of the Medical Society. No one has ever received more splendid cooperation than I have, and the year has been a united effort on the part of all of us to make this year of the Medical Society one of intense interest in organized medicine on the local, state, and national level. The medical profession owes a great deal to organized medicine, and together we have accomplished our goal of uniting our efforts in support of and interest in organized medicine. This has been manifested by the attendance and interest at committee meetings, public relations meetings, county society and district meetings, hours of telephone conversations

and hundreds of letters, all of which attest to the fact that we need each other and in a closer relationship of togetherness the problems that arise and the issues that we have to face can be worked out.

I wish also to thank the counterpart of the Medical Society, the Medical Auxiliary, for their valuable services; particularly in regard to legislation, mental health, and of renewing our interest in the American Medical Education Foundation. Their capable President, Mrs. Robert L. Garrard, has guided them through a noteworthy year of real accomplishments. Our wives have written hundreds of letters to legislators in regard to medical legislation, they have spoken before lay groups, and they have constantly kept every members of the Auxiliary alert in regard to the latest developments that occurred concerning legislation. In the field of Mental Health they have created a new project with the endowment of a bed at Memorial Hospital at Chapel Hill for mental research. They have encouraged you, their husbands, to be more generous throughout the year to the American Medical Education Foundation, and with their interest we will make a more noteworthy report to the American Medical Association this year. I salute the Woman's Auxiliary and thank them for their cooperation and participation in our program as well as their own.

My sincere appreciation to Dr. Wingate Johnson, as Editor of the North Carolina Medical Journal, along with members of the Editorial board who continue to render valuable service to the physicians of this state. We are proud of our Journal and Dr. Johnson, and we are indebted to him for the service he is rendering as our distinguished Editor.

I must pause now to personally thank the very strong arms of any President, Mr. Jim Barnes, and the members of the Executive Office. Without them I could not have functioned in any capacity.

To Mr. William Hilliard, our very capable Assistant Executive Director, in charge of Public Relations, my appreciation for directing the many activities involving the committees and communications of Public Relations.

To Mr. John Anderson, our very able attorney, many thanks for helping us to stay out of trouble, and for his wise counsel when we did confront some knotty problems.

To Mrs. Annette Boutwell, our very capable Community Health Counselor, our thanks for rendering valuable service in the field of Community Health.

To the very efficient secretaries at the Headquarters Office, my appreciation for

their consideration of each and every detail concerning this year's work.

As President of the Medical Society, my year has been an enlightening, broadening, and gratifying experience. I have had contacts with many of you which have opened up avenues of discussion and stimulated our thinking along many lines. It has been a broadening experience to know that the effort on the part of each of you in this Society is contributing much towards a total health program for all people. It has been a gratifying experience because the work accomplished in the activities of the various committees has given me the assurance of larger and greater accomplishments of the Society in the future. Three years ago on the recommendation of the Edlund Report, our Society revamped the committee structure by reducing the total number of committees, and last year we completed for the first time the commission plan, setting up six main commissions comprising a total of 42 committees. This year we inaugurated another plan to reduce the time and travel expense to which members of our committees and executive staff are subjected. This was the Committee Conclave which was held in the fall, in September, at Pinehurst. At this time all commissions met with the majority of the committees meeting on Thursday, Friday, and Saturday, and the Executive Council on Sunday, thus enabling the work program of the Medical Society to start earlier than usual. This gave our Executive Director and his staff and the officers of the Society an opportunity to attend many committee meetings simultaneously. Committee functions were started with good attendance at all meetings, and members of committees who served on more than one committee had the opportunity of attending several meetings in one weekend. This Conclave proved to be a most successful arrangement to start the year's program after the May Convention.

I wish now to briefly give you some of the details of the various committee activities and functions that have taken place during the past year. Many of these will be incorporated within the reports that you have already received or will be part of the official transactions of this Society.

This has been a year when Medical Legislation has been foremost in our thinking, and I am happy to report that the State Medical Society has been on the alert in every way in regard to legislation. North Carolina has been singled out as one of the more aggressive states in helping to solve the medical care cost of all ages. The Doctor's Program of Blue Shield, and the Per-

son Home Care (of Chronically ill) Program are now nationally known.

Last July when the House Ways and Means Committee held public hearings on the Forand Bill, your President along with Dr. J. P. Rousseau, Dr. John Robert Kernodle, and Mr. Barnes, were asked by the American Medical Association to represent the State Medical Society at this hearing. Because of the advanced planning and organization in North Carolina, relative to the problems of medical care of the aged, the State Society was asked to present many phases of their study including the recent study survey of Guilford County, the very excellent Person County Home Care Program, the Doctor's Program of Blue Shield, and the development of the Senior Certificate. Dr. John Robert Kernodle, as Chairman of the Chronic Illness Committee, was spokesman before the House Ways and Means Committee. The North Carolina report to the committee was well received and was discussed by several members of the Ways and Means Committee as the views and "activities" of the Medical Society of the State of North Carolina.

Again in October, in St. Louis, Dr. Rousseau, Dr. Kernodle, Dr. Amos Johnson, President-Elect, Dr. Hubert Poteat, Chairman of the State Legislative Committee, Mr. Barnes, and I attended the American Medical Association National Legislative Conference. With the realization that a major legislative battle must be fought during this session of Congress in 1960, key representatives of the American Medical Association and leaders of the State Medical Societies throughout the country were brought together for an alert and briefing session. I am certain that this meeting was a major factor in helping to keep the Forand Bill in committee and was the stimulating influence to help foster the positive program of the American Medical Association and the State Medical Associations concerning legislation relative to the positive plans for the care of our Senior Citizens.

In January, a very successful Public Relations Conference of County Medical Society Officers and Committeemen was held in Pinehurst. Arrangements of this excellent conference were made by Mr. William Hilliard of the Public Relations staff and Dr. E. T. Beddingfield, Chairman of the Committee on Public Relations. This gave County Society officers an opportunity in mid-year to meet together again to evaluate committee programs, to hear reports on successful local projects, to discuss insurance programs, medical legislation, public relations, and to stimulate interest in county, state and national medical affairs. Out-

standing speakers from the American Medical Association and from our own State Society were heard. This meeting served as a very fine liaison between the Committee Conclave held in the fall and our present State Convention.

As President, I also attended the American Medical Association Southeastern Regional Conference on Aging, held in Atlanta, Georgia this past March. Dr. Wingate Johnson, Editor of our Medical Journal was panelist on the program, and Dr. John Robert Kernodle, Chairman of the Committee on Chronic Illness, was a speaker. Programs, plans and problems of the American Medical Association, State and local Medical Societies were presented as they related to the total health care of the chronically ill and aged. Emphasizing the fact that aging is a state of mind and attitude that cannot be legislated and that health care was only one facet of the problem, the broad care of the aging and chronically ill was brought home as a community responsibility of every citizen in our country. I was proud that North Carolina was already solving this in many communities by adopting community programs for the aged.

In regard to insurance programs of our State Society, I am pleased to report that the Senior Certificate that was adopted at our session in 1959 and made a part of the Doctor's Program under the direction of the Blue Shield Committee with Dr. Jake Shuford, as Chairman has been well received. After due deliberation and consultation with Hospital Savings of Chapel Hill, the Senior Certificate was offered to the public in August 1959. I am convinced that as this program expands it will provide broader coverage for the elderly segment of our society. We must continue to emphasize that the voluntary health insurance program and the medical profession's own sponsored Blue Shield Plan offers doctors an opportunity to participate actively in guiding the destiny of our medical prepayment program in the days ahead.

The need for closer and broader communications concerning all phases and activities of the Medical Society cannot be too greatly stressed. This was most vividly experienced during the recent campaign concerning the Forand Bill before the House Ways and Means Committee. As the legislative alert came from the American Medical Association's Headquarters office and the Washington office, many media of communications were employed to carry these to the county societies, committees and individual members. One of the most effective and stimulating was the series of telephone conferences this Society held with county

society officers, committee members, key legislative members and representatives of the American Medical Association who came to North Carolina to participate. Telephone conferences were extended into each district and county of the state, giving representatives an opportunity to hear Mr. Richard Nelson, of the American Medical Association give a detailed account of the national legislative position as it pertained to the Forand Bill, and to outline for each county a positive plan of action.

Mr. Barnes reports that the tangible results have been most gratifying and the response to this conference has demonstrated the effectiveness of this relatively new method of communication. Time, travel, and expense were greatly reduced for officers and members of the administrative staff of the Society. May I strongly recommend that a broader use of the telephone conference be considered in the future.

I attended the annual and interim meetings of the American Medical Association in Atlantic City and Dallas, Texas. At both sessions, Mr. Barnes, and I spent considerable time at the technical, scientific, and commercial exhibits. I found that Mr. Barnes was in his medium here also, as he is well known to many of the exhibitors. His diligent attention to this activity contributes much to the excellent and extensive exhibits we have at the convention this year.

The Medical Society may well consider the advisability of an interim meeting to stress the scientific program of the Society. This perhaps could be incorporated in the fall along with the Committee Conclave, or in January at the Public Relations Conference, thus increasing the educational values or scientific exhibits to all members.

During my years of service on the Executive Council and as President, it has been my definite opinion that the Executive Council and the North Carolina Delegates to the American Medical Association should have closer communication. To promote this, the American Medical Association Delegates, Doctors Elias Faison, Charles F. Strosnider, and Millard D. Hill, have been invited to all sessions of the Executive Council, so as to be available for consultation by the Council on matters pertaining to the American Medical Association's policies and programs. They have been urged to participate in the discussions and deliberations of the Executive Council. I feel that this is a very definite and positive relationship that should be continued and broadened in every feasible way so as to bring about a closer working understanding between the American Medical Association and the component State Societies.

I am pleased to report that the financial affairs of the Society are in good order. We are operating with a balanced budget, and last year the Society had an operating surplus in excess of \$30,000. A detailed financial report will be submitted by Mr. Barnes, the Executive Director and Treasurer.

The Headquarters Office was enlarged last fall giving much needed additional floor space. This permits our Executive office staff to spread their wings enabling them to more efficiently carry out the many details involved in the operation of this Society.

It has been my privilege and pleasure to attend and speak at district meetings, county society meetings, and many functions throughout the state relative to the office as President of the State Medical Society. One of the true pleasures of the year was in having a part in the ceremony at the erection of an historical marker commemorating the founding in 1799, and the reorganization in 1849, of the Medical Society of the State of North Carolina. This marker was erected on the north side of our State Capitol by the Historical Society, and before you leave this convention I hope that you will go by and view this recognition of our great Society.

In closing I wish to express to you my sincere appreciation for placing your confidence in me and allowing me the privilege and honor of serving as President of so great a body of fellow colleagues. This year has been a memorable one, and the work we have done together and the friendships that have been broadened will always be treasured in the years to come. I submit to you as members of the House of Delegates an account of my stewardship as President of the Medical Society of the State of North Carolina. [Applause]

SPEAKERS KOONCE: I would like to remind you to be sure to visit the exhibits on the concourses on each side of the balcony.

Now I am going to call on President Reece for one more chore. While we are waiting I call on the Committee on Credentials to make a report as to the presence of a quorum.

[The Chairman of the Committee on Credentials reported that there were 117 delegates.]

SPEAKER KOONCE: As I understand it, it takes 101 for a quorum, so I declare 101 present and the session officially in order with a quorum. Dr. Reece!

PRESIDENT REECE: There is just one further thing I would like to say. I have

often said that the President's jewel should go to Mr. Jim Barnes, because he is the "gem" of our Medical Society. No president can function without this fine person to guide him along the course during his tenure of office. Without his help and direction many of our efforts could never become achievements. To this devoted Executive Director of our Medical Society, I personally, and I know that you as members of the Society offer our sincere thanks for untold hours of service to us. As he becomes the President of the National Medical Executive Directors Association in June, we congratulate him upon receiving this high honor, and are proud that he is our "gem" from North Carolina. I would like for Mr. Jim Barnes to come forward at this time, and I will ask Dr. E. W. Schoenheit to escort him to the platform.

[Mr. James T. Barnes was escorted to the dais.]

Jim, on behalf of the eleven past-Presidents and myself, I would like to present to you these 17 little jewels as a reminder of our appreciation to you as Presidents in helping to steer each one of us through our term of office, and for your services to the Medical Society. We congratulate you on the honor that has been bestowed upon you, and you have our very best wishes as President of your organization during the coming year.

Jim, on behalf of the past Presidents that have served under you and in appreciation of our goodwill and everything you have done for us, I wish to present to you these seventeen little jewels. We love you. Thank you for being the devoted servant that you are. We are proud of you, and may God bless you as you assume your high responsibilities nationwide this year.

MR. BARNES: Thank you Dr. Reece.

[The audience arose and applauded.]

MR. BARNES: Mr. Speaker, President Reece, Secretary Rhodes, Delegates: Of course I am dumfounded. I don't know what in heck to say. No one, I am sure, has ever served in any undertaking that has had grow out of that undertaking the fine love and respect that I have come to hold for the medical physicians groups in this state and indeed throughout the United States.

This honor that you are paying this morning, comes, of course, as a complete surprise to me, as did a year ago the recognition by my fellow-workers in the field of medical administration when I was elected to the position of President-Elect of the Medical Societies Executives Association of America. I do appreciate this honor and distinction, and I assure you that it will imbue in me even a greater determination to humbly

serve the high cause of medicine in my state. Thank you so much. [Applause]

SPEAKER KOONCE: Well, gentlemen, pleasant little interludes are about over, and it is time to get down to brass tacks. It is time for me to try to assume the position that Dr. Murphy gave so much dignity and brilliance.

Last year I made many mistakes. I didn't realize I was to be in the chair until the last minute. Those mistakes were through ignorance because I wasn't prepared. This time I read that "bible" of ours about a dozen times, and I ought to know something about it. If I make mistakes today, it is through sheer stupidity.

But I would like to make a few requests as Speaker of the House. I should like to have us limit our discussion as much as possible. We have a lot of problems that are coming up that are very important and should be discussed, but I would like to request, if it is possible, that you only rise to discuss a question once unless the discussion changes the aspect of it, and then feel free to rise again. I think possibly you could limit your remarks to about two minutes in discussion of a question, and, in discussing the question, please speak directly to the question.

Another thing is, so that our reporter, Mrs. Fanny Sweeney, can get all of this down, when you get up to discuss a question, please go to the microphone and give your name and where you are from and try to speak as distinctly as possible.

All of you have a Compilation of the actions of the various and sundry other officers, councilors, commissioners and committees. There will be several committees that will make supplementary reports, and we will call on them as we go along. Otherwise I will just call the agenda item and see if there is any extra report.

Now the report of the Secretary. Dr. Rhodes, do you have anything in addition to the Compilation?

SECRETARY RHODES: Nothing, sir.

SPEAKER KOONCE: Do I hear a motion to accept this report of the Secretary?

[Upon motion made and seconded, it was voted to accept the report of the Secretary.]

(See page 97)

Now the Executive Director, Mr. Barnes, do you have anything to add to your Compilation?

MR. BARNES: Mr. Speaker, the only thing that I would do is to refer to the audit report which is contained as a separate printed sheet in the material along with the Compilation, which is my accounting as your Treasurer, and I would like to have

you look at that. I am a little proud of the year's report.

SPEAKER KOONCE: Do I hear a motion to accept the Executive Director's report?

[Upon motion made and seconded, it was voted to accept the Executive Director's report.]

(See page 98)

SPEAKER KOONCE: The Assistant Executive Secretary, Mr. William N. Hilliard—Bill, do you have any additional report? He is out busy. Do I hear a motion to accept his report.

[Upon motion made and seconded, it was voted to accept the Assistant Secretary's report.]

(See page 168)

SPEAKER KOONCE: Mrs. Garrard, the President of the Auxiliary, has requested that she be allowed to come before us this afternoon.

Now we will go on to the reports of the Councilors.

[Speaker Koonce called on each of the ten Councilors for additional reports, if they had any. There were no additional reports.]

SPEAKER KOONCE: Do I hear a motion that the reports of the Councilors listed in the Compilation be accepted?

[Upon motion made and seconded, it was voted that the Councilors' reports be accepted.]

(See page 105)

SPEAKER KOONCE: Next on our list is the Report on Candidates for General Practitioner of the Year. Three nominations have been made by the Committee on Rural Health. We will have the report by Dr. Hugh A. Matthews. Dr. Matthews is not here and he has sent the following note:

In view of my not being present at the House of Delegates meeting on Monday, May 9, 1960, I submit the following report:

On April 8, 1960, the Committee on Rural Health reviewed the brochures and supporting data on all candidates nominated by County Medical Societies for the G. P. AWARD FOR THE YEAR-1960. Three nominees were selected for presentation to the House of Delegates for final selection of the awardee. They are as follows:

Nominee

RUPERT RYON WEATHERS, M.D.
Knightsdale, N. C. (Wake)
LLOYD HARVEY ROBERTSON, M.D.
Salisbury, N. C. (Rowan-Davie)
WILLIAM ALBERT SAMS, M.D.
Marshall, N. C. (Madison)

To be presented by:

C. T. Wilkinson, M.D.
Wake Forest, N. C.

Thomas Lynch Murphy, M.D.
Salisbury, N. C.
Walter Otis Duck, M.D.
Mars Hill, N. C.

Each nominee is to be presented by the person so designated. Time limit—five minutes each. This concludes my report.

Respectfully submitted:

Hugh A. Matthews, M.D., Chairman
Committee on Rural Health and
G. P. Award

SPEAKER KOONCE: Now we will go to the presentations and then we will have a ballot. Dr. C. T. Wilkinson, of Wake Forest, will speak for five minutes on Dr. Weathers.

DR. C. T. WILKINSON: Mr. Speaker and Members of the House of Delegates: Wake County is happy to present to this House of Delegates for their consideration for the coveted award of General Practitioner of the Year the honored name of Dr. Rupert Weathers of Knightsdale. I have known Dr. Weathers' devotion to his practice and patients for over thirty years. I am flattered to have been asked to place his name before you. I wish that I had the ability to do credit to this great humanitarian, this great yet humble family doctor. Dr. Weathers is now broken in health and unable to attend our meetings. His very life has been given in devoted service. He never sought fame or fortune. He deserves the acclaim of this House of Delegates. Let me read briefly excerpts of a biography written by one of his admirers.

Dr. Rupert Ryon Weathers, born in 1897, the youngest of seven children, grew up on a farm north of Knightsdale. He walked four miles each day to attend the Eagle Rock Academy, then became a boarding student at Wakelon High School. He worked his way through Wake Forest College, graduating in 1924.

While attending the Medical College of Virginia, Dr. Weathers continued to work. He worked one summer at McCain Sanatorium and another at Pine Camp Sanatorium in Richmond. Intern work was done at Old Rex Hospital in Raleigh.

In 1926 he married Josephine Wooden of Charlottesville, Virginia, a graduate of the Nursing School of the Medical College of Virginia. They began their work in Knightsdale in the fall of the same year.

They have one daughter who is Social Counselor at the State Prison for Women. They also have three grandchildren.

Dr. Weathers' affiliations are as follows:

Member of the Wake County Medical Society and Past President
Life Member of the North Carolina Medical Society

Member of the American Medical Association

Member of the Academy of General Practice

Member of the Tri-State Medical Association

Member of Kappa Psi Medical Fraternity

Member of the North Carolina Academy of General Practice

In 1941, the proprietor and owner of Knightdale Pharmacy died. Dr. Weathers got a permit from the Board of Pharmacy to operate the store under his license until 1956 when a trusted clerk became a licensed pharmacist.

He has given freely of his time in all kinds of immunization clinics held in white and colored schools. He assisted in the Salk Polio Clinics at both schools. He worked in many other community activities in the medical field.

The O'Neal girls of Raleigh, who were on the National Polio Posters for the year 1953, were among the many babies delivered by him.

He delivered 2100 babies in homes during his practice. He also delivered many at Rex and Mary Elizabeth Hospitals.

Dr. Weathers always took a personal interest in the religious, civic and political life of Knightdale. He has been a leading citizen for over thirty years.

In 1927 he was instrumental in getting the town chartered and the first street lights installed. He participated in the building of the first high school gym and the paving of the first town street.

During World War II he was declared essential to the welfare of the community, being the only doctor in town. During this period of 1942-1946 he served as Mayor of the town of Knightdale.

After the war he worked to secure for Knightdale a water system, a new fire station and town office.

Dr. Weathers quiet manner, as well as dry wit, made many express the opinion that his visit alone did them good, but each knew he could rely on his thorough, up-to-date medical knowledge and skill.

This love for and reliance on Dr. Weathers as a family physician has been felt by rich and poor, by colored and white. Everyone has always recognized in him a deep love for mankind. This love has always been expressed to his fellowmen in medical service when needed, whether payment for the service could be made or not. The community in which he lives is most fortunate to have had for their doctor and friend this great and

humble man.

He will deliver no more babies and his tour of duty as a family doctor is over due to a cerebral accident.

Gentlemen, I present the name of Dr. Rupert Weathers of Knightdale. [Applause]

SPEAKER KOONCE: Thank you, Dr. Wilkinson. Dr. Tom Murphy of Salisbury, will present the name of Dr. Lloyd Harvey Robertson.

DR. O. S. GOODWIN [Apex, North Carolina]: Before you do that, may I second the nomination of Dr. Weathers of Wake County? I would like to take this opportunity to second what Dr. Wilkinson has said and to say that I think of all the men that I have had an opportunity to work with, there was none that was more ethical, more devoted to duty, than Dr. Weathers. I would like to take this opportunity to sanction what has been said about him and to second the nomination.

DR. THOMAS L. MURPHY [Salisbury, North Carolina]: I want to present on behalf of the Rowan-Davie County Medical Society the name of Dr. Lloyd Harvey Robertson for the very high honor of General Practitioner of the Year.

I am sure that many of you know Dr. Robertson. He has attended these meetings regularly for thirty years and has been a delegate from Rowan-Davie County Society for the past four years. In 1957 he was the program chairman for the General Practice section. He is well known for his ever present cigar, his open friendly manner, and for his hearty laughter. He is one of the few men I know who can fish hard in Currituck Sound for two days; come in empty handed; and still be in good humor.

However, in selecting a man whom we consider an ideal physician, much more has to be taken into account than his personality and charm. We are interested in a man who represents the ideal physician. Now what makes Dr. Robertson outstanding? First of all, I would like to cite his clinical judgment which is superb. He is one of those rare gifted individuals who can very quickly pick out the organically sick patient from the neurotic patient. He does this by good bed-side, clinical observation and knowledge. Laboratory tests are used when indicated but not as a substitute for clinical thinking. Secondly, Dr. Robertson has that rare gift, for which we can all envy him, of knowing what he knows and knowing equally well what he does not know. He has done a remarkable job of keeping up with current developments in medicine through reading and regular attendance at Medical Meetings. He was a charter member of the

A.A.G.P. and I do not believe that he has missed more than one of their National Meetings. When Dr. Robertson encounters an obscure and difficult problem he is very quick to call a consultant. To see one of his patients in consultation is always a challenging experience. In addition to his superb clinical judgment and his absolute honesty with himself, Dr. Robertson genuinely likes his patients and respects them as people. To him a patient is a sick individual who needs help, not just a source of income. Although he sends out bills only once a year he has managed to make a more than adequate living.

It is a rewarding experience to ride around Rowan County on a Sunday afternoon with Dr. Robertson looking for quail. At the farm houses where we have stopped he has usually treated two or three generations of the family and at each home he is an honored guest. The children swarm around him so that it is difficult for him to even get into the house. The complete devotion of his patients to him has made his life rich.

A busy dedicated medical practice such as Dr. Robertson has leaves little time for other activities. When he was younger and could get by with less sleep he was interested in fox hunting and was President of the North Carolina Fox Hunters Society and was one of the founders of the U. S. Open Fox Hunting Events. He was interested for awhile in raising fox hounds and had from his hounds one National champion and three U. S. Open champions. He is a civic leader, heading the Selective Service Board of Rowan County and actively leading in the Lions Club.

As may be expected he has been active in the Rowan-Davie Medical Society, having held most of the elective position in this Society. Now he holds the unofficial position of the "man who gets things done". Recently the Forand Bill problem was handed over to a committee headed by him. In a short while everyone in Rowan County had heard of the Forand Bill and had an opinion regarding it. In addition, Dr. Robertson is one of those rare individuals who will stand up in the Medical Society and state what he really believes. He is particularly outspoken when anything comes to his attention that would indicate poor medical practice, particularly practices designed to help the physician rather than the patient. If we all lived by his principles we would have no problem with our public relations. Dr. Robertson has been active with the A.A.G.P. since its inception.

In closing I would like to borrow a particularly descriptive phrase from Honorable

Lindsey Warren. He would describe a man such as Dr. Robertson as a "sizable fellow." Thank you.

SPEAKER KOONCE: Thank you, Dr. Murphy. These nominations do not require a second, but if there is one prepared to second, it will be received. If not, we will go on to Dr. Walter Otis Duck, who will present the name of Dr. Sams.

DR. WALTER OTIS DUCK [Mars Hill, North Carolina]: Mr. Speaker, Members of the House of Delegates: William Albert Sams was born on December 29, 1888, at Flag Pond, Tennessee, the son of Ella McCarthy Sams and Lee W. Sams.

The Sams name is a prominent one in the history of the mountain area of east Tennessee and western North Carolina. Dr. Sams' maternal grandfather, Will McCarthy, was a Baptist minister born and reared in New York City. He came south in the mid-1800's, and for a year was Governor of the Cherokee Indian Reservation; then, he was elected President of Weaver College at Weaverville, North Carolina.

As President of that institution he raised the sheep, tanned the hides and wrote the college diplomas in Latin with his own quill.

The boyhood days of William Albert Sams were unspectacular. Yet, they must have fostered within him an undying love for the people of the rugged mountain area, for when he grew to manhood he chose to devote his whole life to the health and welfare of these people.

He studied at Carson Newman College in Jefferson City, Tennessee, at Mars Hill College, in Mars Hill, North Carolina, and received his M.D. degree from Lincoln Memorial University in Knoxville, Tennessee, now the Medical School of the University of Tennessee. In 1911 Dr. William Albert Sams was graduated second in a class of twenty-six.

In December before his graduation he had married Leta E. Davis, a lovely young woman from Marshall, North Carolina. Eventually they were blessed with four daughters, one of whom died at the age of two and a half.

Dr. Sams' medical practice has been in two distinct phases, one covering seven years in east Tennessee and the other covering forty-one years in his present location in Marshall, North Carolina.

In April 1911, shortly after his graduation from medical school, Dr. Sams set up practice at Unicoi, Tennessee. Thus began a long, colorful, and useful career as a general practitioner.

Those first seven years may well have

been the hardest of Dr. Sams' career; they certainly were the most difficult from the standpoint of transportation and the crudeness of medical equipment and medicines. These were the days before the miracle drugs and ready-to-take medicines. It was essential that a doctor know his chemistry well and that he have a deft touch for measuring out drugs carefully on powder papers with his spatula.

For the first seven years of his practice, Dr. Sams reached most of his patients, scattered far back in the hills, valleys, and coves of the rugged mountains, riding horseback.

It was during his days of practice at Unicoi that Dr. Sams enjoyed the rare distinction of serving as Acting Sheriff of the county. He was Coroner of Unicoi County in 1914 when the Sheriff died, and under appointment by the Governor he filled that vacancy for seven weeks.

On February 1, 1919, he began the second phase of his life as a general practitioner—and he's still on the job!

For the first six weeks Dr. Sams rode horseback to reach patients as he had done for seven years at Unicoi; then, he purchased a Dodge touring car. Roads were poor, however, and often he went as far as he could in the car and then walked the remainder of the way up the side of a mountain to a crude shack to minister to the sick or to deliver a baby.

One of the outstanding phases of Dr. Sams' lifetime of service as a general practitioner has been the delivery of babies. He has presided over the birth of approximately 3,000 babies—all of them home deliveries.

In his first year of practice at Marshall, Dr. Sams began trying to reorganize the Madison County Medical Society. He became President of the group and has since served in all of its various offices. Today he enjoys being the confidant and advisor of each member of our Society.

Dr. Sams has for many years been active in the programs of medical groups outside his own county. In 1938-39 he served as President of the Tenth District Medical Society. In 1947, upon the death of Dr. D. M. McIntosh, Dr. Sams was appointed councilor for the Tenth District Medical Society, a position in which he has served faithfully and enthusiastically ever since.

Dr. Sams attended the first meeting of the American Academy of General Practice in Cincinnati in 1948. That same year he assisted in the organization of the North Carolina Academy of General Practice and was elected its initial Vice President. The following year he was elected President of the Organization. In 1950 he was a delegate

from the North Carolina Academy to the American Academy.

At the most recent meeting of the AAGP in San Francisco, Dr. Sams, was one of three delegates present who had attended all twelve annual meetings of the AAGP House of Delegates.

One may only guess how a man as busy with his career and its allied interests as Dr. Sams has been through the years could find time to take part in the civic and religious life of his community and state; yet, Dr. Sams has been a leader in both of these fields.

As might be expected, Dr. Sams, the grandson of a Baptist minister, is a Baptist. For years he has been a member of the Marshall Baptist Church. He has served on the Board of Deacons and for many years has been a teacher in the Sunday School.

He has long been a crusader for progress through the political life of his community, state, and nation. In 1923 while serving as Mayor of the town of Marshall he promoted the development of the town's present water system. He also has served as County Health Officer for Madison County and County Coroner.

An interesting sidelight on Dr. Sams' political activities reveals the respect which even his political opponents have for him. Shortly after he made public announcement of his candidacy for Coroner in 1958 an opponent for the office ran the following advertisement in the county paper:

"Let Dr. Sams Take Care of the Living and Let Me Take Care of the Dead."

Apparently the voters trusted Dr. Sams to "take care" of both the living and the dead, for he was elected and is still serving as Coroner.

Dr. Sams' keen interest in lawmaking has made him a trusted advisor to legislators today, especially on bills dealing with medicine and public welfare.

Looking back on the long and useful life of William Albert Sams, one is impressed with the manner in which he has upheld the highest and noblest traditions of the medical profession. For a man who has been or still is today:

A General Practitioner
Public School Teacher
Clerk in a General Store
Acting County Sheriff
County Coroner
County Health Officer
Mayor

Member of the North Carolina General Assembly
Army Doctor
Thirty-Second Degree Mason
Shriner

Exalted Ruler and State President in the Elks Lodge
 Church Deacon and Sunday School Teacher
 President, Madison County Medical Society
 President and Councilor, Tenth District Medical Society
 President and Vice-President, North Carolina Academy of General Practice
 Member and Delegate to American Academy of General Practice
 Loving Father, Husband, and Christian Gentleman, what more fitting benediction could his colleagues add than that of "General Practitioner for 1960"?

SPEAKER KOONCE: Thank you, Dr. Duck. The election of General Practitioner of the Year, as you know, is by written ballot, so I will ask you, on the slips that Mr. Hillard has passed out, to make your selection. I will ask you to write your selection, and I will ask Dr. Ralph Garrison, Dr. Joseph Hooper, Dr. Alfred Hamilton, and Dr. Merle Bonner if they will serve as tellers. Dr. Garrison as Chairman will bring me a report, and we will announce the General Practitioner of the Year when that report comes in.

Dr. Leonard Larson, I understand, has come in. Dr. Larson, will you stand and be recognized? [Applause] We are glad to have you, sir, and we will expect to hear from you this afternoon.

We will continue with our business while we are waiting for the report from the tellers. Next is the Report of the Delegates to the American Medical Association. Do the Delegates have any further report?

[There were no further reports from the Delegates.]

SPEAKER KOONCE: Do I hear a motion that the report of the Delegates to the American Medical Association be accepted?

[Upon motion made and seconded, it was voted to accept the report of the Delegates

(See page 163)

SPEAKER KOONCE: Now the Report of the Related Organizations. First is the Report of the North Carolina Board of Medical Examiners, Dr. Combs. I assume he has no further report. Do I hear a motion that it be accepted?

[Upon motion regularly made and seconded, it was voted that the report be accepted.]

(See page 161)

SPEAKER KOONCE: Next is the Report of the North Carolina Hospital Saving Association. Is there any further report on that? Do I hear a motion that it be accepted?

[Upon motion made and seconded, it was

voted that the Report of the North Carolina Hospital Saving Association be accepted.]

(See page 108)

SPEAKER KOONCE: The Report of the Hospital Care Association—is there a representative here to make an additional report? If not, do I hear a motion that it be accepted?

[Upon motion made and seconded, it was voted that the report of the Hospital Care Association be accepted.]

(See page 109)

SPEAKER KOONCE: The Member of the North Carolina Medical Care Commission, Dr. Brewer. I assume he has no further report. Do I hear a motion that it be accepted?

[Upon motion made and seconded, it was voted that the report be accepted.]

(See page 111)

As you know, with our new setup we have Commissioners who have charge of a group of committees under their section. In order to facilitate our moving along, I will call on each Commissioner for an additional report if he has one, and then if he has a Committee Chairman of one of his committees under his commission that he wants to have make a report, if you will give me that man's name I will recognize him. The first is the Administration Commission, Dr. Benton.

DR. BENTON: Will the chair please recognize Dr. Jesse Caldwell?

SPEAKER KOONCE: Do you, Dr. Benton, have any further report to make in connection with finances?

DR. BENTON: I have not.

DR. CALDWELL: Thank you, Mr. Speaker. President Reece, Ladies and Gentlemen: This report is not in your Compilation due to the currentness of the question.

This is a report of a Special Ad Hoc Committee to the Finance Committee that has the duty of investigating the possibility of this Society's sponsoring a program to receive the benefits from the proposed Keogh bill, H.R. 10, which is now in the Senate Finance Committee (of Congress).

In this report there will be a request for action on the part of this House of Delegates.

In 1957, Dr. William A. Sams called the attention of this body to legislation before Congress at that time which was known as "The Self-Employed Individual's Retirement Act" H.R. 9 and 10 or the Jenkins-Keogh Bill. This matter was further discussed by Dr. J. P. Rousseau and a resolution was passed that this House of Delegates go on record as heartily endorsing H.R. 9 and 10.

In 1958 Dr. Lennox Baker arranged for

this matter to be considered by the Executive Council of this Society.

In 1959 a special committee was appointed by Dr. Baker to follow this proposed legislation (known then as the "Self-Employed Individual's Retirement Act of 1959" or the Keogh-Simpson Bill).

The committee was also to advise on the feasibility of the Society sponsoring a retirement plan under this Bill for benefit of our members.

At the meeting of the House of Delegates in 1959 the advantages of this proposed legislation were presented by two experts on the subject who presented the cases from the Trust Fund and the Annuity aspects.

This body then approved a report which recommended that this Society take action which would endorse the Retirement Program mentioned in principle and authorize the committee to act on behalf of the Society to implement the provisions of the Keogh-Simpson Bill (or similar bill) if passed, for the benefit of its members.

Since May 1959 there has been no further Congressional action on this matter. It had passed in the House of Representatives by that time and has been in the Senate Finance Committee. Chairman Byrd has indicated the matter would be considered soon without further hearings. It is anticipated that some provision will be passed to benefit the self-employed—perhaps slightly different than H.R. 10.

Representatives Jenkins and Simpson have died in the past 2 years and the bill is now known as the Keogh bill.

Your special (ad hoc) committee has kept up with this legislation and meanwhile has studied some retirement plans for other medical groups, namely, the Canadian Medical Retirement Savings Plan, the plans offered to members of the American Academy of General Practice, the American College of Obstetrics and Gynecology and the Florida Medical Association.

It is the opinion of members of the committee that a statewide plan is the most desirable from many aspects and we have drafted a tentative plan which could be sponsored by this Society.

PRELIMINARY DRAFT OF PROPOSED NORTH CAROLINA MEDICAL RETIREMENT SAVINGS PLAN

1. NAME—The name of this program is the NORTH CAROLINA MEDICAL RETIREMENT SAVINGS PLAN.

2. PURPOSE—The purpose of this plan is to implement the provisions of the "Self-Employed Individuals' Retirement Act" for the benefit of those herein declared eligible to participate.

3. PARTICIPANTS—Any member of the Medical Society of the State of North Carolina who qualifies in accordance with the "Act" is eligible to join and participate in the NCMRSP. Also, bona fide employees of members of the Society are eligible provided the member, as the employer, has fulfilled the requirements in setting up a retirement plan for his employees as provided under the "Act."

4. GROUP BENEFITS—The plan enables certain economies and advantages to be made available because of group participation, such as group purchase, central accounting, average and continuous buying of securities, wider diversification, adaptability to adjust for inflation, and diminishing trust operation charges as the trust fund grows larger.

5. FLEXIBILITY OF PROGRAM—Two separate media are provided for investing and participants may avail themselves to one or the other or a combination of each.

A. The Restricted Retirement Annuity Plan—This plan is designed to accumulate monies which are allocated now and to return these savings to the participant, with interest and dividends, after retirement, in the form of a level pension. This part of the plan will be administered by a leading life insurance company licensed in North Carolina.

B. The Restricted Retirement Trust Fund—This plan will invest deposits in stocks and other securities provided by the "Act" and will reinvest dividends continuously so as to gain benefits from compounding. Participants in this plan will receive their equity from the fund upon retirement in one of the methods of distribution available at that time.

C. A member may participate in either one of the above mentioned plans or a combination of each. For example, he may wish to place \$400 annually in the annuity plan and \$600 annually in the trust fund, etc.

6. DEPOSITS—A participant is committed to deposit a total of at least \$300 yearly which may be one or both portions of the plan. A \$100 minimum each year is required if the member participates in the annuity plan. A maximum deposit is provided by the "Act" and the participant must certify that this maximum is not exceeded in this or other retirement plans under this act.

7. COLLECTIONS—Participants may deposit in the plan at any time by depositing monies in a special account in the -----
----- Bank. Monies deposited

will be transferred to the plan on the first business day of each quarter or any other day as may be designated to comply with the provisions of the "Act" (at transfer participants will be given credit for purchase of units in the trust fund and or minimum payment in the Annuity Plan).

8. CERTIFICATE AND STATEMENTS—On joining the plan a participant will execute an agreement of participation and thereafter he will receive an annual statement of his account and a certificate regarding the deposits made that year (to be used for income tax exemption purposes).

9. FUNDS LOCKED IN—Once funds are contributed to the plan they can only be used for retirement purposes and can only be withdrawn at a penalty, as provided in the "Act."

Your committee would like to submit this resolution to the House of Delegates:

WHEREAS, the members of the House of Delegates of the Medical Society of the State of North Carolina recognize that legislation known as "The Self-Employed Individual's Retirement Act" may be passed by Congress in the near future, and

WHEREAS, it is recognized that certain benefits may accrue to members of this Society by participation in a statewide plan, rather than in smaller local plans or larger national plans, and

WHEREAS, it seems possible that this Society may administer such a plan without expense to the Society; be it

RESOLVED, that the President appoint a Retirement Trust Committee, and,

FURTHERMORE, that this Retirement Trust Committee be authorized to negotiate and the President be authorized to execute a trust agreement on behalf of the Society, with banking and insurance institutions, in order to implement the provisions of such retirement benefit legislation on behalf of the members of this Society and their bona fide employees.

Mr. Speaker, I move the adoption of this resolution.

(See page 94)

SPEAKER KOONCE: Thank you, Dr. Caldwell. According to our present bylaws, that motion is out of order at the present time. A resolution has been presented which will have to go before the Resolutions Committee and be brought back with a recommendation tomorrow afternoon for action. So I will turn that resolution over to the Resolutions Committee for report tomorrow. Do I hear a motion with the exception of that resolution to accept the Administration Commission's report?

[Upon motion made and seconded, it was

voted to accept the Administration Commission's report with the exception of the resolution referred to above.]

(See page 113)

SPEAKER KOONCE: Next is the Advisory Study Commission. Dr. Shuford, but before we go ahead, I would like to announce the results of the General Practitioners vote. Dr. Sams was elected by a vote of 86 out of a possible 134. I wonder if Dr. Wilkinson would bring Dr. Sams to the stand. ([Applause])

Dr. Sams, it gives me a great deal of pleasure to present you with this Outstanding General Practitioner of the Year Award.

DR. SAMS: Mr. Speaker, Fellow-workers: Having served on this committee when it was originally planned as its Chairman for a period of some seven or eight years, and having bestowed this on various ones of my coworkers in North Carolina, somehow this sort of overcomes me.

Personally, I am not worthy of it. I know good and well that the North Carolina Academy of General Practice numbers today around five hundred, and I say to you candidly that I am just one of the five hundred, any one of whom is just as much entitled to one of these as I am.

Of all the things in my life that have occurred, this is one of the most joyous. I appreciate it so much. I wish I were not so broken, but I can only say I thank you. [Applause]

DR. SHUFORD: Mr. Speaker and Delegates: I would like to call your attention to Page 24 in the Compilation. This is the report of the Advisory Study Commission. There are eight committees on this commission, and I am going through them one by one but not in any detail.

The first is the Committee Advisory to the Auxiliary and Archives of Medical Society History. There is no change.

No. 2 is the Committee on the American Medical Education Foundation.

Dr. Garrison has asked me to add the information under a. that to the \$6,000 of gifts to date to AMEF in 1959 has been added approximately \$8,500. I would also like to call your attention to paragraph c., the first sentence. The committee calls attention to the fact that gifts can be made through AMEF and earmarked for the school of your choice without affecting the total amount that the schools receive from AMEF otherwise. That in essence means that if you sent your money in to one of the three medical schools through AMEF and earmarked it for your school of choice, your school would receive that gift and in addition it would not affect the total amount that they receive as a grant from AMEF. If

it was sent through AMEF, then your statistics and your comparison with other states in total gifts would look much better than thirty-third, and that is where we stand now.

On the Committee on Blue Shield, there is only one additional item of information under Item h. on Page 25. The Hospital Care Association of Durham was approved by the Executive Council of the State Medical Society as qualified to sell and administer the Doctors' Program (prepayment medical service). Hospital Care has made application for recognition to National Blue Shield Plans. The additional information was that this recognition was not given at the meeting in Los Angeles in April 1960. It was not denied, but they were not given recognition by the National Blue Shield. The Committee on Accreditation or Approval delayed action.

As for the Committee on Constitution and bylaws, Dr. McMillan will report later.

There is no change in report item No. 5, the Committee on Medical Credit Bureaus.

There is no change in the Committee to Work with the Industrial Commission of North Carolina.

No change in the Committee on Medical Care of Dependents of Members of the Armed Forces.

No change in the Committee on Student A.M.A. Chapters in North Carolina.

There is an Ad Hoc Committee on the Relative Value Fee Schedule, Dr. Everett Pugg (Durham) being Chairman, and he wrote me a letter as a form of report, that the Relative Fee Schedule has been completed by all the specialties except for the Subcommittee on Internal Medicine. Apparently they have had some difficulty resolving their problems. We had hoped to present the Relative Value Fee Schedule to the House of Delegates at this time. However, we will be unable to do so. As soon as it is completed we will report it to the next meeting of the Executive Council. Thank you!

SPEAKER KOONCE: Thank you, Dr. Shuford. Is there any discussion of this report? If not, do I hear a motion to accept it with the additions that Dr. Shuford has made?

[Upon motion made and seconded it was voted to accept the report with the additions made.]

(See page 113)

SPEAKER KOONCE: Next is the Annual Convention Commission by Dr. Raney.

DR. RANEY: The Annual Convention Commission has nothing to report in addition to what was covered in the Compila-

tion. As a matter of fact, this meeting is in a way the final report of the Annual Convention Commission.

[A motion was made and seconded that the report of the Annual Convention Commission be accepted.]

DR. ERNEST W. FRANKLIN, JR.: As Chairman of the Mecklenburg County Delegation and President of the Mecklenburg County Medical Society, I should like to invite the Society to come to Charlotte at the earliest date it can possibly arrange it. We thought that possibly after the Asheville meeting, which has already been set, I understand, for next year, that we would like to have you as our guests for the following year. We would like to present that to the House of Delegates at this time.

SPEAKER KOONCE: I am going to call you out of order because that doesn't come under this report. You have already extended this invitation; it will be brought up on the floor at the time the Nominating Committee makes a proposal as to the places where we hold the convention. When the Nominating Committee report is made, then we will have your discussion, but this does not come under this commission report. Is there any further discussion?

[There being no further discussion, the motion to accept the report of the Annual Convention Commission was put to a vote and carried.]

(See page 114)

SPEAKER KOONCE: Next is the Professional Service Commission, Dr. Paschal.

DR. PASCHAL: Mr. Speaker, I have little to add to the Compilation. I would like to take this opportunity to thank the various members of the different committees for their work.

In regard to the Committee on Insurances, I would like to make one or two remarks by way of emphasis. Dr. Joseph Hooper is Chairman of this committee, and through his efforts, and through the participation of the membership of this Society, we have been able to accomplish two rate reductions during the past year which have accrued to the marked benefit of our membership.

We would like to point out for that committee that it feels that the liability program endorsed and supported by this Society and administered by the St. Paul Fire and Marine Insurance Company is the best type of liability insurance offered to the membership at this time.

With increased participation by the membership, I think we can expect possibly further reductions in premium.

The Committee also wishes to emphasize that no claims were settled by the St. Paul

Company prior to thorough investigation by the Committee on Insurances through specialty type panels set up in the areas involved throughout the state.

I mention that again and I reiterate it by reading from this report because in one area of the state I understand a panel has been set up to work in conjunction with local attorneys. That we think is good interest, but we think that the brainwork of this committee provides what is necessary as far as that is concerned and those in the different areas of the state who feel the need of such I believe can have their work simplified for them by consulting Dr. Hooper and his committee.

I have no further report on the Committee on Eye Care and Eye Bank.

The Physician's Committee on Nursing has no additional report, nor does the Committee on Postgraduate Medical Study. The Committee on Necrology has nothing new to add.

On the Committee on Emergency Medical and Military Service, there is possibly one thing which should be brought to the attention of the membership, and that is the fact that we have recently participated on the state level in an operation which was carried out on a national basis. This was done last week, and the committee had representation. It was pointed out by General Edward Griffin and other members of his state staff on Civil Defense that there is an apparent apathy on the part of the membership of this Society in helping carry out the full program that has been outlined.

We have prepared our own plan of participation, it is being expanded, but it needs the cooperation of each and every doctor in North Carolina, and if and when we are faced with a crisis or an emergency such as was demonstrated in the trial run last week, if we are not better prepared we will be in an awful fix, I believe, as far as carrying out our responsibility to the people of the state is concerned.

Consequently I would urge full participation, and we should like to try to get each of you to stimulate interest in your local emergency medical organization in the communities.

Mr. Speaker, that terminates my report, and I move its adoption.

[The motion was seconded, was put to a vote and carried.]

(See page 115)

DR. LENOX BAKER: I rise to discuss one thing in this committee's report and lend emphasis to it if I may. Dr. Paschal mentioned that in one area a committee had been set up between the local doctors

and the local attorneys, and he pointed out the importance of that group working through Dr. Hooper's committee. I would like to emphasize, from what I get from lawyers, the importance for us in every community where we can to have a medical-legal committee made up of doctors and lawyers to try to settle some of these functional affairs that come up in which we are both interested.

It has been my privilege during the past two years to work with Mr. Paul Horton who is on the law faculty of Duke University, setting up a course in medical-legal jurisprudence which is invaluable to us in our teaching. He thinks that each one of the local committees should always work through the State Society's Committee, and this is a plea for all of us to go home, contact our lawyers, and try to set up such local committees.

SPEAKER KOONCE: Is there any further discussion?

DR. WESTBROOK MURPHY: This St. Paul (insurance) idea was my baby, and I can't resist the temptation to do a little bit of bragging. I would like to call to your attention that according to agreement and based on the loss experience in the state of North Carolina and not in California or New York, reductions up to 40 per cent in the premiums have been made possible. The strength of this program is in direct relation to the participation by the members, and I take this opportunity to beg and urge the members of the Medical Society of the State of North Carolina to acquire this insurance particularly in view of its eminent success.

SPEAKER KOONCE: Thank you, Dr. Murphy. Is there any further discussion of this report?

SPEAKER KOONCE: Next is the Public Relations Commission, Dr. Beddingfield.

DR. BEDDINGFIELD: Mr. Speaker, Dr. Hubert Poteat is actually the Chairman of this Commission. My name is there as a result of a misprint, but I do serve as Chairman of one of the committees in this commission, the Public Relations Committee, and we do have a small amount of additional report on the Public Relations Committee.

First is a very pleasing item. As most of you know, this Society participates in the work of the Annual Science Fair, encouraging high school youngsters throughout the state to develop interest in the sciences and participate in the State Science Fair program. State winners are chosen both in the field of physical science and in biological science, and in addition, because of our interest, we pick a medical society winner who may or may not be a winner in the state contest.

This medical society winner is invited, at society expense, to display his exhibit at our annual session. Some of you have seen those at past sessions. I call particular attention to that this year because the youngster whose exhibit was chosen as the best and who was invited to display here at this annual session was Dr. John Robert Kernodle's son. His exhibit on cancer is in the scientific exhibits, and I invite all of you to go by to meet him and see his exhibit.

The second additional item from the Public Relations Committee has to do with the fact that at the January, 1960, meeting of the Executive Council in Pinehurst a group of physicians from Harnett County appealed and informed the Council that it had come to their attention that a movement was afoot here in the state to establish drug dispensaries in the local county Health Departments throughout the state. Apparently this grew out of the need for expensive tranquilizer type drugs for people found to be medically indigent. However, it apparently grew beyond the furnishing of this particular type of medication, and it was thought there was a movement afoot to supply many types of medication through the county health departments. It appears that this program was encouraged if not actually promulgated by the State Department of Public Welfare. The Executive Council expressed concern over this trend, feeling that a dangerous situation to the public health could arise wherein secretaries, nurses, and so forth, would be dispensing potent medications essentially without current medical supervision to anybody and everybody through the County Health Departments. It was felt that there were other dangers also and that this would disrupt the drug trade and the public safety here in the State. This could become an unbarable expense to our public health setup.

The Council expressed opposition to this trend of dispensing various type medications indiscriminately in county health units and appointed me as Chairman of the Public Relations Committee to work with the representatives of the pharmacy profession here in the State to ascertain just what our policy should be.

Consequently I have held meetings with representatives of the North Carolina Pharmaceutical Association and with the Secretary of the State Board of Pharmacy, Mr. H. C. McAlister.

We learned during the course of these meetings several things. First of all, the pharmacy representatives were very pleased that we had concern and taken the stand and that we did want to draw the line some-

where on this indiscriminate procurement of drugs by anybody and everybody. We also learned that the Board of Pharmacy has just started a survey covering not only the Health Departments but also the various unorthodox methods of drug distribution, such as certain industrial units, the State Hospital System, and out-of-state mail order discount prescription houses.

In an effort to determine the scope of this problem, the Board of Pharmacy in their survey has requested our help in getting physicians who are county medical society officers to find out just what is going on in their counties, and send this back in.

This report was brought to the attention of the Executive Council yesterday and was accepted.

Now I come to my main point. The Council authorized the Committee on Public Relations to disseminate this questionnaire to each county medical society and to its officers. When we get back home you will shortly receive this questionnaire. This is important. We urge that you read it carefully, fill it out properly, and return it so that we will have some idea as to the magnitude of this problem.

I have two other items. The Attorney General of this State has ruled that the out-of-state mail order discount prescription houses are violating the pharmacy laws of this state, and he has authorized the Board of Pharmacy to issue orders to cease and desist to each one of these out-of-state mail order houses as soon as it is learned that they are doing business here in North Carolina.

Therefore, if any of you have patients—and I would like this information disseminated in your county society—who are taking prescription type medication from out-of-state mail order prescription houses, that information should be transmitted to the State Medical Society Headquarters, and we will turn it over to the Board of Pharmacy, and upon investigation orders to cease and desist will be issued to that mail order house.

The final item is this: The Executive Council yesterday passed a statement of policy which is to be disseminated at this time to the State Board of Health, the State Board of Public Welfare, local health boards and local welfare boards, wherein the Executive Council of the State Medical Society disapproves of the trend of establishing drug dispensaries in the county health units. We have in effect asked them to slow up on this until this problem can be thoroughly studied by the pharmacy people

in connection with the Medical Society, at the end of which study we will propose some solution wherein these drugs can be obtained reasonably through the traditional drug houses, namely the retail drugstores.

I was informed by Dr. Norton informally that having learned this trend and having learned of the position of the doctors and the pharmacists, he has already issued slow-down if not stop orders, and that this is apparently not as much of a problem now as it was a few months back, but still it was thought wise that the Society should take a stand in opposition to this trend. [Applause]

SPEAKER KOONCE: Thank you Dr. Beddingfield. There was a mistake. Dr. Beddingfield was listed as Commissioner of Public Relations, but Dr. Poteat is Commissioner and Dr. Beddingfield is the Chairman of the Public Relations Committee. Dr. Poteat, I apologize. Do you have anything additional to add?

DR. POTEAT: No, sir.

SPEAKER KOONCE: With Dr. Beddingfield's additions, do I hear a motion that the Public Relations Commission's report be accepted?

[Upon motion made and seconded, it was voted that the report of the Public Relations Commission be accepted.]

(See page 117)

SPEAKER KOONCE: Now the Public Service Commission, Dr. John R. Kernodle.

DR. KERNODLE: Dr. Koonce, Delegates of the 1960 Convention: I would like to report to you the Commission's activities which were compiled and acted upon yesterday in the Executive Council. I have a few additional changes which I will take up rapidly.

Committee No. 1, the Committee on Anesthesia Study, headed by Dr. Davis, no changes.

Committee No. 2, the Committee Advisory to the Board of Public Welfare, Dr. J. Street Brewer, Chairman, no changes.

The Committee on Cancer, Chairmaned by Dr. James Marshall, no changes.

The Committee on Child Health, Chairmaned by Dr. Angus McBryde, requested an additional \$90 for their budget for the year 1960.

The Committee on Chronic Illness, Chairmaned by myself, has four additional recommendations that were not in the Compilation. These matters were brought to our attention after attending the White House Conference Planning Committee meeting in Chicago ten days ago. Therefore, they were not in my thinking prior to that meeting. We had an additional meeting last week and

thought it best to bring these matters to your attention.

Change Number 1: We recommend that we as physicians publicly let it be known our interest and intent to serve the health and medical care needs of all persons regardless of age or ability to pay for services. This approach will de-emphasize the public appeal for increased medical services just for the aged.

Recommendation Number 2: That each county society elect one delegate and one alternate to the Governor's Conference on Aging to be held July 27-29 of this year. That each physician help in any respect that he can in encouraging medical participation in the Governor's Commission and Committee meeting on aging in July and likewise in representation of our forty-eight delegates to the White House Conference in January, 1961. The Council approved yesterday the expenditure of up to \$100 per delegate to the 1961 White House Conference in Washington.

Number 3: The Council recommended and approved that we secure outside press coverage for the July White House Conference at the Governor's level and that expenses be maintained at a maximum of \$100.

Number 4: It was recommended that the support of Dr. Stanford's committee report for increasing pooled hospital funds for full paying of per diem hospital cost of indigent cases be endorsed and aided.

The Committee on Maternal Health, headed by Dr. James Donnelly, no change.

The Committee on Mental Health, Chairmaned by Dr. Choate, no change.

The Committee on Occupational Health, Chairmaned by Dr. Harry L. Johnson, actually no change in this committee's report, but I would like to reiterate that on October 10 to 12, 1960, the American Medical Association Congress on Industrial Health will be held in Charlotte. All physicians are invited to participate. North Carolina has been singled out as a leading state in industrial development by this particular AMA Congress in Charlotte as the community best suited for the conference at this time.

The Committee on Poliomyelitis, Chairmaned by Dr. Samuel F. Ravenel. Your committee asks that they be allowed to involve themselves in immunization other than polio, only after liaison with other committees (objectively) interested in immunization.

The Committee on Physical Rehabilitation, Chairmaned by Dr. George Holmes, no change.

Committee on School Health, Chairmaned

by Dr. Irma Henderson Smathers, no change.

Committee on Veterans Affairs, Chairman by Dr. Samuel L. Elfmon, no change.

Mr. Speaker, I move the adoption of this report.

[The motion was seconded, was put to a vote and carried.]

(See page 119)

SPEAKER KOONCE: Now we come to the Committee on Nominations which will be reported by President Reece.

PRESIDENT REECE: Mr. Speaker, in compliance with Chapter V, Section 2 of the By-Laws of the Medical Society of the State of North Carolina, the Committee on Nominations had delivered to me at least two weeks in advance of this session a sealed report, the report of the Nominating Committee. That I now open in your presence for presentation to the House of Delegates.

This is addressed to me as President of the Medical Society of the State of North Carolina.

Dear Mr. President:

I have the honor to present the report of the Nominating Committee, Medical Society of the State of North Carolina. The report is as follows:

For President-Elect, Dr. Claude B. Squires

For First Vice President, Dr. Ted Raiford

For Second Vice President, Dr. Charles T. Wilkinson

For Speaker of the House of Delegates, Dr. Donald Koonce

For Vice Speaker of the House of Delegates, Dr. Edward Schoenheit

Respectfully submitted,

Hubert Poteat

Chairman of the

Nominating Committee

SPEAKER KOONCE: Thank you, President Reece. Nominations for Hospital Savings Association and Hospital Car Association come under G. in our agenda, and those nominations will come from the floor.

You have heard the Nominating Committee's report. Are there any nominations from the floor?

DR. LENOX BAKER: Under Chapter V, Election of Officers, there is a sentence which reads: "No member of the Nominating Committee shall be eligible to succeed himself but once."

Farther down in Chapter V it says, Election of Officers, Section 2. "In case of vacancies occurring in the committee or of discovery that any member is ineligible, the Executive Council shall have power to fill this vacancy."

This was called to the Nominating Committee's attention, and I rise to make this Nominating Committee official and therefore hereby nominate those people from the floor and move their election by unanimous vote cast by the Secretary.

[The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.]

SPEAKER KOONCE: I forgot. I probably should not be here calling for a vote on myself. I should have turned that over to somebody else.

The President-Elect then is Dr. Squires, First Vice President Dr. Raiford, Second Vice President Dr. Wilkinson, Speaker of the House Dr. Koonce, Vice Speaker Dr. Schoenheit, and that stands as it is.

The reason I put off the President of the Mecklenburg Medical Society is that I was under the impression that the Nominating Committee had made definite recommendations as to where the next three meetings would be held. Dr. Poteat, will you come up and make such a report?

DR. POTEAT: Mr. Speaker, the report of the Nomination Committee in regard to the annual meeting was made to the Executive Council. I did not realize that it needed to be made to the delegates.

For your information, the recommendation is that the meeting in 1961 will be in Asheville, North Carolina, in 1962 in Raleigh, in 1963 in Asheville.

SPEAKER KOONCE: As I understand it, those are not final.

DR. POTEAT: That is correct.

SPEAKER KOONCE: Those are recommendations to be ratified by this house.

DR. POTEAT: That is correct. I move the adoption of the report.

[The motion was seconded.]

SPEAKER KOONCE: I will now call on the President of the Mecklenburg County Medical Society if he would like to say something pertinent to that.

DR. ERNEST W. FRANKLIN, JR.: I would just like to repeat what I have previously offered, and that is an invitation to come in 1962 to Charlotte. If it is not possible, maybe you can come at a later date.

SPEAKER KOONCE: Gentlemen, there is a motion on the floor.

DR. POTEAT: May I discuss the motion very briefly, and particularly for the benefit of the Mecklenburg County delegation. The Executive Director of our Society informed the Nominating Committee that it was necessary to make plans for at least three years in advance for a meeting of this size. Therefore the recommendation was made, and at the time the Nominating Committee met

there was no communication from the city of Charlotte. Therefore the report is as made.

SPEAKER KOONCE: The motion has been made and seconded that these three places be accepted subject of course to emergency revision if necessary.

DR. FRANKLIN: If this schedule is settled, I would like to invite them then in 1964.

SPEAKER KOONCE: We will certainly turn that over to the Nominating Committee at the proper time.

There is a motion on the floor. If it is accepted, these three sites will be those approved.

[The motion was put to a vote and carried.]

SPEAKER KOONCE: Next is the Committee on Grievances, Dr. Owens. Do you have any report?

DR. OWENS: We have nothing further to report.

SPEAKER KOONCE: There is no report of the Grievance Committee, and since Dr. Owens has no report, we need no action.

The Committee on Negotiations, Dr. William F. Hollister.

DR. HOLLISTER: I have no further report.

SPEAKER KOONCE: Dr. Hollister has no further report. That is in the Compilation on Page 97. Do I hear a motion that it be accepted?

[Upon motion regularly made and seconded, it was voted to accept the report.]

(See page 150)

SPEAKER KOONCE: Next is the report of the Executive Council by Dr. Reece.

PRESIDENT REECE: There are several items coming from the Executive Council. First, the 1960 budget was adopted.

You have been given the abridged report of the Executive Council Sessions of September, 1959 to January 31, 1960. It contains a budget. Copies of this have been distributed to you before your arrival. This budget has been approved by the Executive Council and is brought to the House of Delegates as a report.

SPEAKER KOONCE: Do I hear a motion for the adoption of the budget?

[Upon motion made and seconded, it was voted to adopt the budget.]

(See page 178)

PRESIDENT REECE: This concerns the Life Membership.

The Executive Council recommends the adoption of the following recommendation to and by the House of Delegates:

That Whereas, The Constitution of the Society formerly provided that those mem-

bers who had been members of the Society for 30 consecutive years would be entitled to Life Membership and should be exempt from all dues and assessments, and

Whereas, Section 6, of Article IV of the Constitution was amended at the last Annual Meeting to read: "Life Members shall consist of those physicians who had been members of the Society consecutively for 20 years and who had attained the age of 70 years",

NOW THEREFORE BE IT RECOMMENDED:

1. That the foregoing amendment to the Constitution changing the requirements for Life Membership is interpreted as becoming effective as of January 1, 1960, and as not applying to or affecting the status and privileges of those members who had become Life Members or who had become eligible for such membership by completing 30 consecutive years of membership before January 1, 1960.

2. That the foregoing amendment to the Constitution is interpreted as being applicable to all other members who had not completed 30 consecutive years of membership in the Society.

3. That the present Life Members who are engaged in the active practice of medicine and who are financially able to do so be solicited to voluntarily pay the regular membership dues to help support the work of the Society.

SPEAKER KOONCE: Resident Reece. That is a recommendation from the Executive Council. I think you understand that that entails no change now in the By-Laws or the Constitution. It is purely a recommendation as to the interpretation of the present Constitution and By-Laws. Therefore, we ask for a vote from the House of Delegates to support that interpretation by the Executive Council and the Executive Office group. Do I hear a motion that those recommendations be accepted?

[A motion was made to adopt the recommendation which was seconded.]

SPEAKER KOONCE: Do you understand this recommendation?

FROM THE FLOOR: No!

PRESIDENT REECE: We apparently need some clarification before we take a vote on this recommendation.

As you will recall, the old Constitution and By-Laws stipulated—let me know if I make a mistake when I am quoting this—that a man would receive life membership when he had paid dues to the Medical Society of North Carolina for a period of 30 years. We changed that and instituted a new procedure, that a man attained life member-

ship when he became 70 years of age and had been a paying member for 20 consecutive years.

Under the old arrangement, the interpretation that we had, many members that had been paying dues for 30 years and had attained the life membership status had to start paying dues again. But we are changing the interpretation of that, and any man who had attained the status of life membership January 1, 1960 does not have to start paying dues again, but we do solicit that he support the Society, and if he is gainfully employed in the practice of medicine and is able to carry on an active practice we solicit continuation of his financial support.

This was brought out in very extensive discussions at the Executive Council Session of the Society. I would like to give you the feeling of several members.

Many members of the Society that had attained life membership were perfectly willing to start paying dues again, and this was discussed very extensively. We are changing here only the interpretation. Any man that has attained life membership does not necessarily have to be a dues-paying member again, but we are soliciting and urging that he support the work of the Society.

SPEAKER KOONCE: I might add a little to that. The interpretation of the Executive Council group was that with the change in the Constitution which went into effect in 1959 all members, regardless of whether they had previously attained life membership or not, who had not reached the age of seventy would become dues-paying members. There was considerable resentment from some of the life members on the basis of being compelled to give up something that they had attained as a right.

After discussion, as indicated, the Executive Council therefore went on record and made the recommendations that have just been presented. The recommendation is that it be interpreted that a man who had reached life membership prior to 1959 remain as a life member with all of the privileges of the Society without paying dues if he so wishes, but we would like for such members to pay dues if possible as we could use the money. That is exactly how simple it is.

Does this answer your question, sir? Is there any further discussion?

DR. BENTON: I am Chairman of the Finance Committee, and I am vitally interested in this. We need the money badly, and I want to point out that if you should demand your money back, then it will be necessary to go to your income returns that you file with the government and pay the

government for what you paid us. That will be a lot of trouble.

If it becomes necessary to get the money by other means so that we have to assess deductible.

DR. FAISON: I think it would be interesting to know just how much this change would mean to the coffers of the Medical Society per year. I think Mr. Barnes knows that figure.

MR. BARNES: As of the ratification of the change in 1959 there were 540 life members. Now, due to deaths and loss, it is reduced to a net of 502 as of December 31. Of the 502, 252 have paid dues for twenty years and have attained the age of seventy as of January 1, 1960. Therefore they were not assessed dues as of January 1, 1960. That leaves 250 who held life membership eligibility and or status, who from January 1 were billed for 1960 dues as required under the amended Constitution and By-Laws in effect January 1, 1960. Of that 250, 165 have paid those dues and 78, I believe is the figure—anyway the difference between 165 and 250 still had not paid those dues as of Thursday or Friday of this past week.

SPEAKER KOONCE: Is there any further question?

[The motion was put to a vote and carried.]

SPEAKER KOONCE: Those recommendations as to interpretation of the Constitution will be followed up by the Executive Committee.

DR. POTEAT: Mr. Speaker and Members of the House of Delegates: In April of this year, the House of Delegates of the Florida State Medical Society adopted a resolution commending members of the Congress and others who had opposed certain health measures, particularly the Forand bill. The Executive Council of our Society at its annual meeting on last Saturday directed me as Chairman of the Legislative Committee to prepare and present here a resolution as follows:

Whereas, The Congress of the United States has for several sessions considered various bills relative to providing and subsidizing the sickness costs of the aging, and

Whereas, The physicians of the State of North Carolina consider such bills to be socialized medicine for a large but special group of our population, and

Whereas, The estimated cost for any of these plans is astronomical and unpredictable, and

Whereas, The vast majority of individ-

uals over the age of 65 do not require federal assistance, and

Whereas, In North Carolina physicians have always contributed their services to the care of the indigent and semi-indigent of all ages, and

Whereas, Extensive studies on county levels in North Carolina have failed to demonstrate any degree of unmet needs which would warrant Federal participation in providing care for any age group, and

Whereas, It is the desire of the members of the Medical Society of the State of North Carolina to improve the medical care for all persons, and

Whereas, The members of the Medical Society of the State of North Carolina feel that political medical practice would hinder and not improve this medical care

NOW, THEREFORE, BE IT RESOLVED, That the House of Delegates of the Medical Society of the State of North Carolina meeting in annual session in the City of Raleigh, North Carolina, this the ninth day of May 1960 commend those members of the Congress and all others who have maintained a steadfast opposition to furthering the cause of socialism, and

BE IT FURTHER RESOLVED, That, the American Medical Association's positive eight point program for the care of the aging be endorsed, publicized, and efforts at implementation expanded, and

BE IT FURTHER RESOLVED, That a copy of this resolution be sent to the President of The United States, the Vice-President of the United States, the Speaker of the House of Representatives, the members of the House Ways and Means Committee, the Secretary of Health, Education and Welfare, the Governor of the State of North Carolina, the Honorable members of the North Carolina Congressional Delegation, the members of the Board of Trustees of the American Medical Association and to all State Medical Societies.

Mr. Speaker, I respectfully submit the resolution.

SPEAKER KOONCE: This is a resolution which will go to the Resolutions Committee and be brought back tomorrow for consideration.

PRESIDENT REECE: This is a short resolution concerning Alleghany, Ashe and Wilkes County Medical Society. The resolution was first that Alleghany County wishes to change its affiliation and Ashe wishes to change its affiliation. Dr. Sams made the motion. Mr. President, there is nothing we can do but endorse the thing if the doctors

of Alleghany County want to do it.

SPEAKER KOONCE: That is under New Business, but since it is recommendation from the Executive Council, and it has to be approved the House of Delegates, do I hear a motion for approval?

[Upon motion made and seconded, it was voted that the action of the Executive Council be approved.]

(See page 177)

[There were announcements by Secretary Rhodes.]

SPEAKER KOONCE: Gentlemen, we will now recess until two-thirty. Please come back promptly at two-thirty so that we can get started and get through.

[The session recessed at twelve thirty-five o'clock.]

MONDAY AFTERNOON SESSION

May 9, 1960

The House of Delegates reconvened at two-thirty o'clock, Speaker Koonce presiding.

SPEAKER KOONCE: I would like to call the meeting to order again after the luncheon recess. At this time we are privileged to have the President of the Medical Auxiliary, Mrs. Robert L. Garrad, if she will come forward and give her report.

[The audience arose and applauded.]

SPEAKER KOONCE: I will ask Dr. Reece if he will introduce Dr. Larson.

PRESIDENT REECE: To those of you that have attended the sessions of the American Medical Association in the past few years, I am sure that all of you were impressed with the very effective and dynamic man from North Dakota as he functioned as Chairman of the Board of Trustees. It is with particular pleasure that we have Dr. Larson to come and visit us in North Carolina for this occasion.

First, he has a family in North Carolina. His daughter, his son-in-law, and his five grandchildren live in Lenoir, and they are friends and neighbors of mine, so that on the several occasions that I have seen him when he has visited North Carolina, I have told him that I would invite him to come and be with us when I was President this year. He has consented to come, and we are working him very hard.

Dr. John Rhodes took him to the Rotary Club today. He is to speak to us this afternoon, and he will really be at home in a House of Delegates because he has been there many times before both in the American Medical Association and his own State Society.

Dr. Larson, without further ado, because we all know you, thank you for coming and

being with us. We welcome you to North Carolina. [Applause]

(Dr. Leonard Larson presented an address to the House of Delegates entitled *THE THREE GREAT CHALLENGES*, published in the North Carolina Medical Journal, Vol. 21, No. 7.)

[Applause]

SPEAKER KOONCE: Thank you, Dr. Larson. We are scheduled at this time to have the election of the Nominating Committee. As you know, a member of the Nominating Committee from each district is nominated at a caucus of members of the House of Delegates of that district with the District Councilor serving as Chairman of that committee. If Mr. Hilliard will get these signs arranged, we will have a temporary recess at which time the members of the House of Delegates of the different districts will gather and bring to me a nomination from the Nominating Committee of that district. Let us remember that that action is a nomination; it is not an election. They nominate to the House of Delegates their representative from that district, and then we have to elect from the House of Delegates. If you will nominate as fast as you can and get your report to me as quickly as you can we will reconvene as soon as that is over.

[There was a brief recess.]

SPEAKER KOONCE: Gentlemen, if you will take your seats please, I will read the nominations for the Nominating Committee with the understanding that none of these men have served over one year.

First District—Zack D. Owens

Second District—Karl B. Pace, Sr.

Third District—Robert Fales

Fourth District—M. A. Pittman

Fifth District—R. L. McMillan

Sixth District—Paul F. Maness

Seventh District—Jesse Caldwell

Eighth District—Charles Norfleet

Ninth District—Jake Shuford

Tenth District—Theodore S. Raiford

Gentlemen, do I hear a motion from the floor that these nominations be put into effect?

DR. SAMS: I move that the nominations be put into full effect as recommended.

[The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.]

SPEAKER KOONCE: The newly elected elected Nominating Committee will promptly assemble in Room 105 at the north end of the Coliseum under a temporary Chairman who will be designated by Dr. Rhodes as Secretary.

I will again call on President Reece to introduce our next speaker.

PRESIDENT REECE: Mr. Speaker, it is also a privilege and real pleasure to have with us another guest to speak to the House of Delegates today.

I, personally, invited Dr. Stubbs to come and be with us in North Carolina because of his intense interest and his vast amount of knowledge concerning the Blue Shield plan as it operates in the United States.

The whole southern part of the United States is a little bit low on Blue Shield coverage compared to the rest of the country, and we are making every effort in North Carolina to expand and make the Blue Shield really mean something in providing health care for the people.

To help us arrive at a solution of the problems we have and expand this, it was suggested to me that we invite Dr. Donald H. Stubbs from Washington, D. C. He is an anesthesiologist, he is a Southerner from Georgia, and he also says he is a states-righter. He was here yesterday and talked to us at the Executive Council.

There are several other things we can say about him, that although he lives and he practices medicine in Washington, D. C., he lives south of the Potomac in Virginia. Dr. Stubbs, we welcome you.

In spite of living out there, Dr. Stubbs is the President-Elect of the District of Columbia Medical Society. He has many other outstanding accomplishments, and he is to receive the National Health Award on June 1st for his outstanding work in Blue Shield insurance programs.

At present he is the Chairman of the Board of Trustees of the National Blue Shield.

Dr. Donald H. Stubbs, from Virginia and Washington, D. C.! [Applause]

DR. DONALD H. STUBBS: Mr. Speaker, Mr. President, Members of the House and my Friends of North Carolina: I address you as friends because, as has been indicated, I was born in Georgia and live in Virginia. North Carolina is a suitable meeting place for these parts of my history, and my wife and I like it very much to make visits here not only because of the friends we have here but you have other attractions as well—the mountains and the ocean.

A number of years ago I was invited to participate in a scientific session at Asheville and in the course of correspondence to get things straight for my trip to Asheville it was thought originally that my wife might go with me, and so I received a letter from the Secretary saying, "We have reserved a double room for you and Mrs. Connelly, and we hope that you have a nice time while you are in Asheville."

Now, Dr. Connelly of Johns Hopkins was

also on the program with me—he is hematologist there—and I was rather concerned whether I should publicize this invitation until I met Dr. Connelly, saw that he was bigger than I and what kind of a family they were. They were a delightful couple, and so I have told this before to illustrate the lengths to which the good people of North Carolina will go to make someone come to a meeting. [Laughter]

I was younger then, and they used a different kind of attarction, I suppose.

Now, I had had an invitation from the President, Dr. Reece, from Dr. Rhodes, the Secretary, and it was formally conveyed by Mr. Barnes.

I have a certain kinship also with Amos Johnson as was indicated here, because he and I are sharing at this moment the anxieties and apprehensions of those who go into the Society Presidency, and we have hopes, too, that it will work out well. But I know also, as has been indicated here to you today, that if we lost our Executive Secretary in Washington, I would forthwith resign as President-Elect because certainly a mere practicing physician is not in a position to go on to one of these jobs in these troubled times by himself.

I am pleased to follow Leonard Larson on this program. He asked me what I was going to say, and of course I couldn't answer because I never know that myself, but I did say I would be glad to follow my leader, and I do acknowledge Leonard as a leader of you and of me in such matters as those of which he spoke. I feel particularly pleased to be on a program with him because he as Chairman of the Board of Trustees of the American Medical Association, I as Chairman of the Board of Directors of the National Blue Shield, have, I think, a rather definite parallel obligation to the medical profession. His is an over-all type of leadership involving basically the scientific aspects of medicine which brought us together many years ago, but these have become overlaid in considerable part, as he has indicated to you, by the pressing necessities of economics, and, believe me, economics is the business of medicine, and no one need be ashamed of doctors being in this business. The idea that we should leave all of this to outside interests, stay out of the insurance business, is an outmoded idea and one we should throw out as quickly as possible because unless we stay in it and unless we get into it more, these things that we already are losing piecemeal will certainly be lost to us more rapidly because it is true that the voluntary health insurance system has grown to such size and to such acceptance among our people that it cannot pos-

sibly be superseded by anything except a regimented system.

I say that I am willing to follow Leonard. Even George Washington couldn't always be first. You remember, first in peace, first in war, and first in the hearts of his fellowmen, but he married a widow.

While I am talking about Larson, to make this thing as friendly as possible, when he took a little pocket knife out of his pocket like this one that I used to operate on rats with when I was a pathologist, he explained, "This is not a fighting knife," and you would think a man like that would have to have a big one if it were," this is a medicinal knife. Snake bites, you know. If one bites you on the ankle, you cut out a little piece of flesh, suck out the blood, and you are all right." So the obvious question was, "Suppose you sit down on a snake up there in the Black Hills, what then?"

"That's when you find out who your friends are." [Laughter]

Well, he has plenty of them down here in North Carolina, and I am glad to be here with him.

What is National Blue Shield? What is Blue Shield itself? Well, Blue Shield is a local movement that has sprung up in isolated spots all over this country as a non-profit prepayment type of mechanism with physician control in somewhat varying degree but significant control, and now there are sixty-five of these plans in the United States. We have them available covering all areas of the country except for four states, which are relatively light in population. Two of them are Nevada and Idaho. New Mexico is just about on the verge of coming in. Louisiana is about the only populous state that is on the outside, and ever since Huey Long set up the charity hospital system they have been a little bit on the edge.

But it is a movement that has developed a great deal of cohesion, and now we have it functioning on the national level just as Blue Cross function on the national level.

I said that health insurance had grown to a point where we cannot brush it aside, where this has been so accepted by the people, so demanded by the people, that we must continue and expand it. Five out of every seven Americans has some health insurance, and the other two include even the indigent and those who don't want it and will never have it.

But only two out of seven dollars of the \$16 billion that go into health services by rather recent estimates are paid by the insurance mechanism, and for this reason the demand now is not so much a demand to

make it available to additional people as it is to make more care available to the individual person.

Along with this, the demand is becoming more insistent that we know what the price will be of the medical care so that prepayment may be effectively given and given without the mechanism of prepayment itself producing an inflation of the costs of medical care.

The very factor of control in hospitals of the Blue Cross mechanism, which is prepayment basically for hospital coverage, and of the control among physicians of Blue Shield plans lends some suspicion always to the thought that there may be a selfish motive in carrying on these plans.

We are cautioned that physicians to the very extent that they control their Blue Shield plans must be sure that they operate in the public interest and not simply as collecting mechanisms.

The problem of recent years has been one of developing the national picture for the reason that these plans are local, they don't cross state lines notably in their subscriber lists, but so many of our people do cross state lines frequently, so many of our national accounts involve many states or even all of the states.

The first legislative program of recent years that involved you and me as practicing physicians, all of us, was the Medicare program, and this was one that we had to subscribe to in a special way because we did not have a national pooling mechanism that would enable us to control this thing at the local level, and we had to set up a very special one of postpayment without insurance involved at all.

More recently the Federal Employee Program came into it, and this was the largest prepayment program of a single type in the United States. On July 1, five million of our own people roughly came under it. But bear in mind that this is only an early set of steps. We already have now, as Dr. Larson has pointed out to you, the Forand type of proposals for legislation, which, with the advent of the Flemming plan within the last week at a level of governmental funds of one billion and a quarter or more to begin with, has already committed both parties in Congress, the Republican Administration in power and so many individual members of Congress, to a program for the aged, and this program that has already been proposed now on both sides is more than ten times as large dollarwise as the Federal Employee Program, and there is real likelihood that a program of some sort will be enacted into law at this session of Congress.

We can say that the Forand bill itself has been killed, as it probably has, or deferred, but even Mr. Forand never said that he wanted his own particular bill to pass. He wanted to use it as a vehicle of discussion and as a basis for attracting to the banner of those who would carry this on more help.

This is an ever widening circle of threat, as Dr. Larson emphasized, and to meet it we have to gather together our forces throughout the country in medical affairs.

You have here in North Carolina your own particular problems, as all areas do. I have had occasion in the last year particularly to go into a number of sections of the United States where problems exist. I should have been yesterday in Michigan where we have been carrying on a joint committee study of the problem of prepayment coverage by their Blue Shield plan. The National Blue Shield organization and the House of Delegates of the Michigan Medical Society, which I addressed last September in a similar manner to the way that I am talking to you now, established this committee to study their problem. We have made very good progress there.

I know that you will solve your problems given the information and the intent on the part of all of you to absorb that information and act properly upon it. Your Committee Chairman, Jake Shuford, has already shown a willingness to work hard as a Committeeman, and many of these others who have been named and whom you know better than I have done the same type of unselfish labor on behalf of this interest.

The thing that I would say to you about the action of the National Blue Shield Board in connection with the application of the Durham Plan, the Durham Blue Cross Plan, for approval as a Blue Shield Plan is that this was continued under study at the national level, for this reason, that a Blue Shield plan can be approved only after it is sponsored or approved by its local society, be it state or county, and then is approved by the national organization as meeting the minimum standards. It is a double approval. But the actual naming of it as a Blue Shield plan is the right and privilege and the duty of the National Board of Directors. You have a Blue Shield plan in North Carolina that is already approved and is already operating. This would be the first time anywhere at any time that a double approval for a given area of operation had ever been deliberately made, and we fear that that taken as an action deliberately would have difficulties, and so we postponed, feeling again that the proper over-all consideration was one that involved you, the House of Delegates representing doctors of this state, and your

Executive agency, the Council, and such committees as you might direct to study this.

This is a matter of too grave importance at this time for it to be carelessly undertaken and to be done in a hurry. You have spent many years getting to this point. You have spent some fourteen years with the Blue Shield plan, which it was indicated has not grown as rapidly as it has in some areas.

I would like to say, as I believe is proper to say to doctors everywhere, that if your Blue Shield plan is not covering the areas, if it is not broad enough, if its Constitution and function is such that you are dissatisfied with it, those of you who are the most dissatisfied are the most obligated to help correct it. You cannot turn your backs on this problem without turning your backs to your duties as practicing physicians.

So "Durham" is not rejected, but it is carried under study, and in connection with this study the National Blue Shield organization offers its services to you as a clearing house of information of what has happened in other areas, how these problems have been met, and it offers itself to you to assist in establishing a proper answer to your problem, and when that answer is established and you send it in appropriately to the national organization, then I would see no reason why such a solution might not be the one that we would strive for.

The time has come again in medicine, as in all our national life, when we must devote ourselves to our field, and we must take up seriously this purpose for which medicine is intended to exist in the first place, the service of our patients. The economic problems of our patients, as of ourselves, have become so paramount in their thinking that doctors cannot shirk the responsibility to assist in solving them. Thank you! [Applause]

SPEAKER KOONCE: Thank you, Dr. Stubbs.

We will now go back to the report of the Executive Council. Dr. Reece has a report on the action of the Executive Council as of yesterday that he wants to read.

PRESIDENT REECE: I am very glad that Dr. Stubbs discussed this problem as it relates to our resolution or information that I am to present at this time.

In the discussion yesterday, Dr. Stubbs came before the Executive Council, and our thought and consideration in the Council was given to it. A motion was made, and I would like to read the motion and its intent. Dr. Johnson made the motion, so it may be that after it is read, he would like to discuss it briefly.

The motion was made that the Executive Council approve the appointment of an ad hoc committee. This committee is to be composed of members of the Executive Council, of members of the now present and operating Blue Shield Committee of the Medical Society, and of members of the boards of the two nonprofit plans within this state, of members of the Medical Directors of the two existing nonprofit plans. These were principally Hospital Care and Hospital Saving. The purpose of the committee was to be to study the situation diligently, to avail itself of all possible sources of information which might lead to a proper solution, and a proper recommendation from this committee to be brought back to the Executive Council at its fall meeting, and that the House of Delegates be made aware of this action of the Executive Council if it follows through on this and their approval be solicited.

There were comments made about this. Dr. Koonce pointed out that if this motion is passed and acted upon by the Executive Council, it does not necessarily need to come up to the House for approval, but simply should be submitted in the report.

That is essentially the statement that was made. Dr. Johnson, do you have any further comments you would like to make about this?

DR. AMOS JOHNSON: Mr. President, unless there should be some desire for further comments, I have nothing more to say, although I will be glad to give the thinking back of it if it is desired that I should do so.

It seems perhaps that after the very lucid and enlightening talk which Dr. Stubbs gave and after the reading of the motion as it was approved unanimously by the Executive Council yesterday, it should be fairly well clear what was meant by this motion. This will be a committee appointed from the Executive Council and from the now present Blue Shield Committee of this Society and also with representation on the committee from the medical members of the Board of Directors of the two nonprofit Blue Cross plans now in existence to study the Blue Shield situation in North Carolina.

As you all are aware, one of our nonprofit companies has been in the Blue Shield business now for some twelve or fifteen years. We have had another one which this House of Delegates or its counterpart a couple of years ago authorized to go into the Blue Shield business if and when the board structure and specifications of the other company which was then selling this type of Blue Shield insurance would allow it.

The Durham group, Hospital Care, met

these specifications, and your Executive Council activated their action and recommended to the National Blue Shield Association that they be given the same privileges as Hospital Saving had. You have heard Dr. Stubbs give the reasons why this was held in abeyance.

Along the line has come the idea that has been advanced to your Executive Council, that there is yet another possibility, that there is a possibility that a third corporation might well be formed in North Carolina whose purpose and action would be to control all Blue Shield policies to be sold in the state of North Carolina, and that this would be then under the almost entire control of the State Medical Society, and it would be sold by and perhaps administered, if we saw fit, on a contract basis by the now present and existing two nonprofit plans, Hospital Saving and Hospital Care.

There are factors to be said for this. I am not speaking for it. I am explaining the factors. The factors are (1) that under the present situation with our Blue Shield set-up it is being handled and administered by a board that contains twelve members. Four of them are from the policyholders among the public, four of them are from hospital administrators, and four are elected by the Medical Society. If we were to form a third corporation we would have a board which would then be perhaps better representative of medicine, and on this board, the hospital administrations would not be necessary—they would be a third party. We would then have a board made up of members, patients, members of the public, subscribers to this, and of medicine.

There are other factors to be said for it, that we would be in control of our own monies and profits which were derived, if you care to call them profits; we could say that any money that accumulated at the end of the year over and above that which was paid out from that which was received in as payment for policies would then be used entirely for the purpose of reducing the premium that would be charged for the policy, the increase of coverage, or it could reflect itself in an increase in the rate of the fees for the services rendered by the physicians of North Carolina. Perhaps, another one, we could, if we had good experience, as has been had by our Blue Shield company, take these policies which we are now selling to our senior citizens and are advertising as coverage for them, which in reality is a bit of a sham—if you get the policy and read it, it deletes and writes out all pre-existing conditions that these elderly people have, so it is not coverage like we would have if Mr. Forand wrote it for them. We could then

pick that up with any excess funds we have, or we could tie it in with all of our policies, and perhaps offer to these elderly people something comparable to what they would get under federal legislation which would give them coverage, because it is reasonable to believe that if a person is sixty-five years of age or older and he has a pre-existing condition, if he is hospitalized or when he dies, the chances are 50 per cent, maybe better, maybe less, and that is a rather arbitrary figure at this time, that that pre-existing condition will be on his hospital admission or even on his death certificate. So actually they are not presently getting the coverage that we would like to believe that they are getting.

There are other factors which would go along also to make us want to give this matter careful consideration. It would help us in our project which the State Medical Society has o.k.'ed and which is now being pursued to remove from Blue Cross policies as they are now in existence and sold both service benefits which should be in the other policies.

We could perhaps, if it were a third corporation and with the control resting within the doctors of medicine—and yesterday Dr. Stubbs, in talking to the Executive Council made the statement that approximately three-fifths of all of the directors of the Blue Shield companies now in existence in the United States were doctors of medicine, so that would mean a preponderance of those on the board—if we had that and we were administering such a policy ourselves, it would be logical and reasonable to believe that we might then get better participation in our Blue Shield coverage for our people by the doctors of this state inasmuch as they would have a better opportunity to control prepayment features.

The whole purpose of coming to you with this was to make you aware of this, to make you know what is going on, and to let you approve of this. If you approve of it, it will be implemented as quickly as possible so that we can for our people of North Carolina as soon as possible offer better Blue Shield coverage.

If there are any other questions or if there are any questions that I have not answered in this rather rambling discussion, I will be very glad to answer them.

DR. RACHEL DAVIS: May I ask Dr. Johnson a question? Dr. Johnson, I think the plan that you talked about is a marvelous plan to increase the service under the volunteer hospital plan. I think this is a great step forward in preventing socialization of medicine.

But I have been seriously wondering if we could not, in the medical profession of North Carolina, take an additional step and come forward with something like a program which will be acceptable to the medical profession not only of North Carolina, but of the nation, to act as a substitute for such bills as the Forand bill.

Here is what I am thinking of: Twelve per cent of our nation is under Social Security, and fifteen per cent of that twelve per cent is medically indigent. Then we have the great group who are at the welfare level. Is it not time for us to come forth with a program in which we would suggest an idea where in the case of an individual with an income of less than \$1000 a year, have his voluntary prepayment insurance underwritten by the Welfare Department and having him himself contribute at least ten dollars of his income toward the cost of that policy which would afford him adequate hospital care, the free choice of physician, and so forth. Would not a program something like that be an answer to the programs like the Forand bill, and could we not set that up with a greater partial payment and a greater indemnity for the medically indigent group just above that? I think here is the field in which we must do some active thinking and take some immediate action.

DR. JOHNSON: If I have interpreted your suggestion correctly, you would want this committee, if it is activated, to go farther than I set out at first to the extent of exploring ways and means of taking care of all of our medical problems in the state of North Carolina.

DR. DAVIS: Right.

DR. JOHNSON: I see no reason why, when this committee is working with those sources of information which we will certainly contact and get to advise us—and by us I mean the committee—we cannot explore all possibilities and report them back and implement them if they are practicable.

SPEAKER KOONCE: To facilitate this, the Executive Committee wants approval from you of the appointing of this committee which is a study committee on Blue Shield which can take up these other problems. I am not going on with the discussion, but I want a motion before the floor. Do I hear a motion, that the action of the Executive Committee be approved?

DR. STROSNIDER: I so move, Mr. Speaker.

[The motion was seconded.]

SPEAKER KOONCE: Is there any further discussion? Are there any questions? The simple problem is to appoint an Ad Hoc Study Committee which will make future

reports to the Executive Committee and to the House of Delegates. If there is not any discussion, I will put the matter to a vote.

[The motion was put to a vote and carried.]

SPEAKER KOONCE: The next on the agenda is to nominate a board member first of the North Carolina Hospital Saving Association, and second the North Carolina Hospital Care Association. The floor is open to nominations for board members of the Hospital Saving Association.

DR. SHUFORD: Mr. Speaker, I would like to nominate Dr. Louis Klostermyer of Asheville to the Board of Trustees of the Hospital Saving Association. Dr. Klostermyer has been on my Blue Shield Committee for a number of years, and I think he is eminently qualified for this position.

[The nomination was seconded by Dr. Sams.]

SPEAKER KOONCE: The nomination has been made. It is not necessary to second it but it was seconded. Do I hear another nomination?

SPEAKER KOONCE: Are there any other nominations? If not, do I hear a motion that nominations for Hospital Saving be closed?

DR. WILLIAMS: I so move.

[The motion was seconded, was put to a vote and carried.]

SPEAKER KOONCE: Now do I hear a nomination for the North Carolina Hospital Care Association?

DR. PASCHAL: Mr. Speaker, I would like to place in nomination the name of a man who has demonstrated his ability and who is well informed in matters pertaining to the Hospital Care Association, who has done already an excellent job. I place the name of Dr. Alfred Hamilton before this body.

SPEAKER KOONCE: Are there any further nominations for Hospital Care?

[It was moved and seconded that nominations be closed.]

SPEAKER KOONCE: The nomination then is Dr. Klostermyer for the Hospital Saving Association and Dr. Hamilton for the Hospital Care Association. Since there is only one nomination for each office, they can be elected by acclamation. Do I hear a motion that these two men be elected by acclamation?

DR. SAMS: I so move.

[The motion was seconded, was put to a vote and carried.]

SPEAKER KOONCE: I should like to make an announcement. Dr. Shuford has been selected as permanent Chairman of the Nominating Committee for the year 1960-1961.

Now, Dr. McMillan, let's have some By-laws.

We will take up Dr. McMillan's report as a committee and also under Old Business I. Ratification of Constitution and Bylaws first read in 1959.

DR. McMILLAN: Mr. Speaker and Members of the House of Delegates: Your Committee on Constitution and By-Laws has met on three occasions during the year—first at the Conclave of Committee-Commissioner Conferences in the fall of 1959 in Pinehurst, secondly at midyear on January 22, 1960 and reported to the Executive Council in Raleigh, and now in connection with the Annual Meeting of the House of Delegates in Raleigh, May, 1960. Several important matters have been considered and resolved or developed into recommendation to the House of Delegates which will follow. Your Chairman is pleased to present this final report for the year.

The Committee has caused to be published the complete revisions of the Constitution and By-Laws which revisions have accrued through actions of the House of Delegates from 1944 to and including all the ratifications of revisions completed in 1959. Same has been made available in this edition to all officials functioning for the State Society, as well as for all officials of the component county societies, and have thus been distributed. Sufficient copies are available for immediate succeeding officials in both the State and Component Societies as well as for any member who may be interested and requests a copy.

The Committee expresses its profound appreciation for the devoted services of the late Moir S. Martin, M. D. to this Society as a member of the Committee on Constitution and By-Laws for the past many years. It expresses deep regret at his loss.

The Committee first refers to those actions of the 1959 House of Delegates in reference only to Articles of the Constitution read for the first time in 1959 and required to be ratified at the 1960 meeting of the House of Delegates, as follows:

Report Item 1. Amend Article VIII, Section 3, by striking out in line 13 of Section 3 the word "active" and inserting in lieu thereof the word "continuous" so as to make this section consistent with privileges expressed to the Scientific Members as provided elsewhere in the Constitution.

I move that this amendment first read and passed in 1959 be ratified as now printed in the "Revisions of 1960".

[The motion was seconded, was put to a vote and carried.]

DR. McMILLAN: Report Item 2. Amend Article VIII, Section 1, by adding after the

word "Councilors" the words, "and ten Vice Councilors". I move that this admendment be ratified as now printed in the "Revisions of 1960".

[The motion was seconded, was put to a vote and carried.]

DR. McMILLAN: Mr. Speaker, I desire to return to this section a little later for the introduction of our ratifying clause later in this report.

Report Item 3. Amend Article IV, Section 7, by: *first* inserting before the word "purpose" in line five the words "continuing educational"; and *second* by striking from lines 14 and 16 the words, "in an amount of ten dollars (\$10.00) per year, or such additional amount".

I move that this amendment be ratified as now printed in the revisions of 1960".

[The motion was seconded, was put to a vote and carried.]

DR. McMILLAN: Now that action having been taken the Constitution and its Articles as printed in the "Revisions of 1960" are complete and fully authorized, Mr. Speaker.

Now the Committee passes on to the By-Laws and makes reference to the By-Laws, more particularly those acted upon on one reading at the 1959 meeting of the House of Delegates.

Report Item 4. A year ago or on May 4 a proposition to amend Chapter IV, Section 14 was raised and referred to the committee on Constitution and By-Laws to effect a revision so that the same elected member could serve simultaneously on the Boards of Trustees of Hospital Saving Association and the Hospital Care Association. However on May 6 the House of Delegates by formal vote on a substitute motion referred this matter to the Committee on Constitution and By-Laws for thorough discussion and report back through the Executive Council to the House of Delegates. At that time an amendment to Chapter IV, Section 14, was proposed to be placed at the end of the section to read as follows: "The same member will be elected to serve on the Board of Trustees of both the Hospital Saving Association and the Hospital Care Association." Now the Committee on Constitution and By-Laws, after thorough study and formal action taken on January 22, 1960 and approved by the Executive Council recommends that the proposed amendment *NOT* be adopted; that the House of Delegates should not be bound or compelled by a provision of By-Laws to elect the same members as the Trustees of both of these Associations and that it would be preferable that the House of Delegates be left free to either

elect same members to both boards or to elect different members to each board as the circumstances and conditions existing at the time of election may justify or indicate. The Committee senses the present Chapter IV, Section 14 is not prohibiting. Unless the House of Delegates differs with the position of the Committee (and we wonder if we are dealing with a proposition of dual office holding) that is all of the business to be reported as brought over from the 1959 Meeting of the House of Delegates.

Now we come to the consideration of entirely new propositions for revisions, so to speak starting a new slate from the printing of the "Revisions of 1960".

SPEAKER KOONCE: Do I hear a motion that the report of the By-Laws Committee, so far as that one section which he just read is concerned be approved? In other words, that it is not compulsory to have the same members on Hospital Saving and Hospital Care.

DR. STROSNIDER: I so move.

[The motion was seconded.]

SPEAKER KOONCE: It has been moved and seconded. Is there any discussion?

DR. THOMPSON [Shelby]: We discussed this report. I don't think we should vote on this thing. We have not had a chance to look it over. We looked for it in the agenda and we couldn't find it. I don't know anything about it. I think it ought to be tabled until the next meeting.

SPEAKER KOONCE: It can't very well be tabled, Dr. Thompson. This is action of the House of Delegates of last year, but they did not confirm the original motion on the first day and turned it over to a committee. The committee reports back that it feels that it feels that the House of Delegates should not be limited, and that there will be no conflict, that they can either be elected to one or both. The motion has been made and seconded. Is there any further discussion. If not, I will put the question.

[The motion was put to a vote and carried.]

DR. McMILLAN: What I say from now on will be read for the first time to the House of Delegates.

These recommendations involve the By-Laws only:

Amend Chapter X, Section 9, subsection "e" of the By-Laws by striking out the last sentence of said paragraph and inserting in lieu thereof the following: "If the accused physician is willing; however, the acting Chairman, in order to expedite proceedings, may instruct the committee member living nearest the accused or the

Councilor or the Vice-Councilor of the District in which the accused physician resides to undertake preliminary investigation, obtain information, and report to the Committee."

Mr. Speaker, I move the adoption of this amendment. It is to be ratified tomorrow afternoon at the second meeting.

[The motion was seconded.]

SPEAKER KOONCE: It has been moved and seconded. Is there any discussion? It is simply to implement the function of the Grievance Committee so that the Grievance Committee can use other people than themselves to facilitate their work. It was a recommendation of the Grievance Committee.

[The motion was put to a vote and carried.]

DR. McMILLAN: Amend Chapter X, Section 9, subsection "h" by striking out the period at the end of the first sentence and by adding thereto a comma and the words, "but this is not to prevent the Committee from informing the physician accused as to the basis of the complaint and supplying him with sufficient details to enable him to prepare an answer".

I move the adoption of this amendment. This is to be ratified tomorrow afternoon.

[The motion was seconded.]

SPEAKER KOONCE: This gives your Grievance Committee full rights to inform an accused physician. Is there any discussion?

[The motion was put to a vote and carried.]

DR. McMILLAN: Amend Chapter X, Section 9, subsection "h", line 8 by striking out the word, "however". I want to say for your information that is just a grammatical error. We want to get out that one word.

I move the adoption of this amendment.

[The motion was seconded, was put to a vote and carried.]

DR. McMILLAN: Amend Chapter X, Section 9, subsection h, line 8 by inserting after the word "complaint" and before the word "will", the following: "except as above provided".

I move the adoption of this amendment.

[The motion was seconded, was put to a vote and carried.]

DR. McMILLAN: Mr. Speaker, Chapter X, Section 9, subsection "j" by striking out all of paragraph "j" and inserting in lieu thereof the following: "When the Chairman is informed by the Secretary of a new complaint he shall decide whether it should be investigated by the whole Committee or by one or more individual members of the Committee or by the Councilor or Vice Councilor of the District in which accused

physician resides. He may designate any of the above to undertake a preliminary informal investigation."

I move the adoption of this amendment, and this has to be ratified at the next meeting of the House of Delegates.

[The motion was seconded.]

SPEAKER KOONCE: Again, in explanation of that, that facilitates the work of the Grievance Committee. It legalizes the way the Grievance Committee has always worked because there are so many grievances which can easily be taken care of by the Councilor, and we have been using the Councilor in the past, but it has not been absolutely legal, and this will legalize it.

[The motion was put to a vote and carried.]

DR. McMILLAN: Mr. Speaker, your committee did not recommend the revision of Chapter X of the By-Laws to establish a standing committee on insurance industry liaison. Rather it reported to the Executive Council the recommendation of the principle that such a committee could be appointed by the President of the Society under the title, Committee for Liaison to the Insurance Industry, representing the Society concerning matters relating to the commercial insurance industry and shall maintain liaison with representative committees of functions relative to commercial insurance as may be authorized or directed by the Executive Council. This recommendation was adopted by the Executive Council on January 31, 1960, and it will have to be reported on for final action. This is a matter of form.

SPEAKER KOONCE: Do I hear a motion that this action be approved, the last paragraph he just read.

[Upon motion made and seconded, it was so voted.]

DR. McMILLAN: Finally, the Lenoir-Jones-Greene Component Medical Society has proposed in a resolution that the Constitution be amended in respect to Article VIII Section 2 to read as follows: "The President, President-Elect, Vice-Presidents, Speaker, and Vice-Speaker of the House of Delegates shall be elected for a *period* (term) of one year. The Secretary shall be elected for a term of three years. The Councilors and Vice-Councilors shall be elected for terms of three years and shall serve not more than two consecutive terms of three years (each), beginning with the elections in 1961, "—but I told them last night it couldn't possibly be carried through in 1961, so they have changed now to 1964"—beginning with elections in 1964, four members (of the Executive Council) (shall be elected) for one year, three members (of the Executive Council)

(shall be elected) for two years and three members (of the Executive Council) (shall be elected) for two years and three members (of the Executive Council) (shall be elected) for three years. Following the expiration of these terms, the Councilor and Vice-Councilors shall be elected for terms of three years (each). All officers shall serve until their successors are elected and installed. The Committee on Constitution and By-Laws has considered this matter and recommendation of the Lenoir-Jones-Greene Component Society and recommends that this not be adopted.

SPEAKER KOONCE: That is a recommendation, not a motion. Do I hear a motion before the floor that the recommendation be approved?

[A motion was made and seconded that the recommendation of the Committee on Constitution and By-Laws be approved.]

DR. PATRICK: Our purpose in attempting to change the section in our Constitution follows in this line of thought. Under our present system, it is possible, although it is not probable, that our Nominating Committee and the House of Delegates could replace all of the Councilors on the Executive Council at any one election. Our second reason is that we feel that if we set up a specific time at which a Councilor might serve consecutively, that in general any board which could possibly perpetuate itself is not healthy for any organization.

Third we feel that it would stimulate a great interest in the affairs of our Medical Society, which we feel is greatly needed.

We do not in any way mean to criticize those who are active and extremely interested in our Medical Society, but we feel that there is a need for more physicians to be interested in the affairs of our Medical Society. Particularly do we feel the need for younger men to have the experience of handling some of the problems in present day medicine with the guidance of men who have been doing this in some instances for a number of years.

DR. BAKER: Mr. Speaker, I just get up for one thing. Where we say under Article VIII, Section 1 "including the President, Vice-President, etc." it is followed by, "the foregoing shall constitute the voting members of the Executive Council", so we will have to modify it.

SPEAKER KOONCE: Would you accept that, Dr. McMillan? Would you accept this and have it read "the four Councilor members or three Councilor members" and so forth? If he would accept that, I think that would answer the question.

[It was accepted.]

SPEAKER KOONCE: Is there any further

discussion of this motion? The motion is, if you understand it, that the House approves the recommendation of the By-Laws Committee, which would be to reject this proposal.

SPEAKER KOONCE: The motion is denied. Therefore, we will hold the floor open to a motion that the Lenoir County recommendation be approved for change in the By-Laws.

DR. FAISON: I would like to have a standing vote on that.

SPEAKER KOONCE: A standing vote has been requested. All those in favor of the motion let it be known by rising.

DR. FAISON: Clarify the motion once again. I am not sure that everybody understands.

SPEAKER KOONCE: The motion as it stands now is to approve the recommendation of the By-Laws Committee, that the By-Laws be not changed according to the request. That is the motion. If it is denied, the recommendation of the By-Laws Committee is killed. Then the recommendation from Lenoir County can go on for vote and be approved. Dr. Faison has asked for a rising vote. All those in favor of the vote approving the recommendation of the By-Laws Committee please stand.

SPEAKER KOONCE: You gentlemen be seated, please. Now will those against the motion please rise. The vote is 66 against and 32 for. The motion is denied.

Now I am informed, according to the action of the Executive Council and the way this is worked, that this question will have to be turned back to the Committee on Constitution and By-Laws for rewording and be brought back to the House tomorrow. [Discussion ensued.]

SPEAKER KOONCE: Gentlemen, if we pass it today it will have to be passed as it is written now, and I don't think that that would be wise. I don't think that is exactly what they want. There will have to be some additions as to which districts will come in at which time. I as Chairman am going to give that privilege (a constitutional provision as expressed) to the By-Laws Committee, that it will be referred to them and they will be directed to bring it back tomorrow.

DR. McMILLAN: Amend Section 1, Chapter I of the By-Laws by deleting the words "Life Members" in line five because it is taken care of in Article IV of the Constitution. There would be a conflict with Section 6.

I move the adoption of this amendment.

[The motion was seconded, was put to a vote and carried.]

DR. McMILLAN: Amend Section 8,

Chapter IV of the By-Laws, which is on Page 14 in your present Constitution and By-Laws, by placing a period after the word "body" in line four of said section and deleting the remainder of that sentence. This is on Page 14, Chapter IV, Section 8: "It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body." In other words it says after that "in such a manner that not more than one half the delegates shall be elected in any one year." I move adoption. Although we now have three, and we can't elect half of three.

SPEAKER KOONCE: That is the purpose. We have been working on the basis of electing our representatives to the American Medical Association, all three of them, at one time. This is just to correct this mistake.

[The motion was seconded, was put to a vote and carried.]

DR. McMILLAN: Amend Section 9, Chapter XV of the By-Laws by adding thereto the following: "A member of one component society may also be admitted to membership in another component society without paying or being included for payment of additional dues to the State Society, with the consent of the component society of the county in which he resides where such additional membership is required for hospital staff privileges."

SPEAKER KOONCE: That has been moved by the Chairman of this committee. Do I hear a second to that motion?

[The motion was seconded, was put to a vote and carried.]

DR. McMILLAN: Mr. Speaker, I would just like to call your attention to Section 1, Chapter XV, County Societies: "A copy of the Constitution and By-Laws of each component society shall be filed with this society." That is on Page 35. If you have lost or cannot locate your County Society By-Laws, you can remedy this by adopting a new set of By-Laws in the form of a revision or restatement, and if you need any help you can obtain a model draft from Mr. Barnes' office. I warn you that all County Societies must have a Constitution and By-Laws and deposit it with the State Society.

DR. LENOX BAKER: Will you go to Section 10, the bottom of Page 4. I think you skipped that.

DR. McMILLAN: Amend Chapter X, Section 9, subsection w, by striking out the second sentence of this subparagraph and inserting in lieu thereof the following: "All statements made to or testimony given by a member of the Society who has been invited

to appear before the Grievance Committee or the Executive Council of the Society shall also be considered privileged communications and shall not render such person or witness liable to any member of the Society."

Insert the following in lieu of the second sentence: "All statements made to or testimony given by any person who has been invited to appear before the Grievance Committee or the Executive Council of the Society shall also be considered privileged communications and shall not render such person or witness liable to any member of the Society."

It did not pass the Executive Council, and I would like to ask our Attorney for a statement on that as to why we left that out last night.

MR. ANDERSON: I think you were just following what the Executive Council instructed. [Discussion ensued at length.]

SPEAKER KOONCE: The Speaker is going to use his prerogative again and refer this back to the By-Laws Committee to bring a definite proposal one way or the other, and in specific writing at the meeting tomorrow. All he can do is to bring it to us, and we can ratify it next year, because there seems to be some confusion as to who wants what when. That ends that report.

DR. PASCHAL: May I speak as Parliamentarian just one moment? I direct my remarks particularly to Dr. Patrick and others who are interested in the support of this amendment (method of electing Councilors) that they have proposed. I want to assure him and all of the delegates here that the Executive Council, in consideration of this thing, had no idea, I think, of trying to dominate the thinking of our House of Delegates. We are glad to have this. Under no provision, even if it were acted upon this afternoon, could final action on this matter be taken this year. As a Constitution change it would have to lay over for another year. It could in effect be reworded and acted upon today. Still, however, it would have to lie over for another year. The problem of rewording this and including the Vice-Councilor, deciding which districts would have representatives for one year or two years or three years, is something we think cannot be done in a matter of a few minutes. Consequently I believe it would be well for our Committee on Constitution and By-Laws to study this thing and redraft it, and, with your help, resubmit it tomorrow, and we will accomplish the same purpose.

THE SPEAKER: We will go to election of Honorary Member:

MR. BARNES: This is a memorandum

from the actions of the Executive Council September 27, 1959:

Let us take note that Dr. Dave Rose of Goldsboro, North Carolina was nominated by the Executive Council in September, 1959 for Honorary Membership in the Medical Society of the State of North Carolina.

SPEAKER KOONCE: According to the By-Laws, an Honorary Membership has to be nominated and elected by the House of Delegates. Do I hear such a motion, that Dr. David Rose be elected by the House of Delegates an Honorary Member.

[Motion to nominate Dr. Rose to Honorary Membership was made and seconded.]

It has been moved and seconded. Is there any discussion?

[The motion was put to a vote and carried.]

SPEAKER KOONCE: Next is a resolution on Dr. Martin.

MR. BARNES:

WHEREAS, This House of Delegates has experienced the long and useful services of Doctor Moir S. Martin as delegate from Surry County and as committeeman and leader in the affairs of this Society, and

WHEREAS, By election of this House of Delegates, and then by appointment by the Chief Executive of the State, Doctor Moir S. Martin served notable and useful years upon the North Carolina Board of Nurse Examiners and later on the North Carolina Board of Nurse Education and Nurse Registration, and

WHEREAS, His services to this Society has been characterized by the same sacrifice and devotion to duty and obligations as manifest in his long and useful practice with patients in the Mount Airy community;

THEREFORE, BE IT RESOLVED, That this House of Delegates express for posterity and particularly to the Surry County Medical Society and his family the sense of great loss to this Society in the death of Doctor Moir S. Martin during January 1960; and

BE IT FURTHER RESOLVED, That the record of this Resolution be spread upon the proceedings of this House of Delegates and that copies be sent to the Surry County Medical Society and to Mrs. Moir S. Martin of Mount Airy.

SPEAKER KOONCE: This resolution will be turned over to the Committee on Resolutions to give definite recommendations tomorrow. Do we have any other new business?

DR. GARVIN [Chapel Hill]: I ask that the House of Delegates reconsider and re-

state its stand on fluoridation of water supply. This was approved in 1950 or 1951, I am not certain of the date. Perhaps some of you are aware of the fact that we in Chapel Hill are trying to get fluorine added to our water. It (system) is owned by the state, and we are having some objections raised.

SPEAKER KOONCE: You are not asking us to reconsider because that action has already been taken. You are just asking for a reaffirmation of the action that was taken then. Do you make that as a motion?

DR. GARVIN: I do.

[The motion was seconded, was put to a vote and carried.]

SPEAKER KOONCE: Is there any other new business or business of any other kind to come before us?

It is with a great deal of pleasure, then, that I now call this House of Delegates recessed until tomorrow afternoon at two-thirty.

[The session recessed at five o'clock.]

TUESDAY AFTERNOON SESSION

May 10, 1960

The House reconvened at two-thirty o'clock, Speaker Koonce presiding.

SPEAKER KOONCE: Since we are now in session after recess, we will take up unfinished business. The first item is the Ratification of Constitution and By-Laws action, Dr. McMillan.

DR. McMILLAN: I shall first read to you from Article II—Purposes of the Society:

The purpose of this Society shall be to federate and bring into one compact organization the entire medical profession of North Carolina.

I move, Mr. Speaker, that the word "entire" in the second line be deleted.

[The motion was seconded.]

SPEAKER KOONCE: This is a Constitutional change and will have to lay over for a year. It will be voted on again at the first meeting of the House of Delegates next May.

[Discussion was called for. There being no discussion, the motion was put to a vote and carried.]

DR. McMILLAN: This was passed yesterday, and it is to be voted on again today. It is an amendment to By-Laws, Chapter X, Section 8, subsection e, by striking out the last sentence of said paragraph and inserting in lieu thereof the following: "If the accused physician is willing, however, the Acting Chairman, in order to expedite proceedings, may instruct the committee member living nearest the accused"—and this is going in that is new—"or the Councilor of the Vice-Councilor of the district in

which the accused physician resides to undertake preliminary investigation, obtain information, and report to the committee." (That is the Grievance Committee.)

I move the adoption of this amendment.

[The motion was seconded.]

SPEAKER KOONCE: You understand, this was passed yesterday, and the motion now is to ratify it.

[The motion was put to a vote and carried ratifying the amendment.]

DR. McMILLAN: Amend Chapter X, Section 9, subsection "h" by striking out the period at the end of the first sentence and by adding thereto a comma and the words, "but this is not to prevent the Committee from informing the physician accused as to the basis of the complaint and supplying him with sufficient details to enable him to prepare an answer."

I move the adoption of this amendment.

[The motion was seconded.]

SPEAKER KOONCE: Is there any discussion?

[The motion was put to a vote and carried ratifying the amendment.]

DR. McMILLAN: Amend Chapter X, Section 9, subsection "h" line eight by striking out the word "however." That is just to correct a typographical error.

I move the adoption of this amendment.

[The motion was seconded.]

SPEAKER KOONCE: Is there discussion?

[The motion was put to a vote and carried ratifying the amendment.]

DR. McMILLAN: Amend Chapter X, Section 9, subsection "j" by striking out all of paragraph "j" and inserting in lieu thereof the following: "When the Chairman is informed by the Secretary of a new complaint he shall decide whether it should be investigated by the whole committee or by one or more individual members of the committee or by the Councilor or Vice-Councilor of the District in which the accused physician resides. He may designate any of the above to undertake a preliminary informal investigation."

I move the adoption of this amendment.

[The motion was seconded.]

SPEAKER KOONCE: It was voted on yesterday and is to be ratified today. Are there any questions?

[The motion was put to a vote and carried ratifying the amendment.]

DR. McMILLAN: I am sorry, I omitted one item in reading. Amend Chapter X, Section 9, subsection "h", line eight by inserting after the word "complaint" and before the word "will" the following: "except as above provided."

I move the adoption of this amendment.

[The motion was seconded, was put to a

vote and carried ratifying the amendment.]

DR. McMILLAN: Amend Chapter X, Section 9, subsection "w" by striking out the second sentence of this subparagraph and inserting in lieu thereof the following: "All statements made to or testimony given by any person who has been invited to appear before the Grievance Committee or the Executive Council of the Society shall also be considered privileged communications and shall not render such persons or witness liable to any member of the Society."

I move the adoption of this amendment.
[The motion was seconded.]

SPEAKER KOONCE: It has been moved and seconded, and I understand this is the first action on this. It will not be ratified until next year. Is there any discussion? This is the item that Dr. Baker discussed yesterday.

[The motion was put to a vote and carried.]

DR. McMILLAN: Now I am coming down to the Lenoir-Jones-Green Component Medical Society, the resolution that was offered yesterday, and the House of Delegates instructed my committee to put it in writing so we could act upon it today (first reading).

Amend Article 8 of the Constitution by striking out Section 2 thereof and inserting in lieu thereof the following:

Section 2. The President, the President-Elect, Vice-Presidents, Speaker, and Vice-Speaker of the House of Delegates shall be elected for a term of one year. The Secretary shall be elected for a term of three years. Beginning with the elections in 1964, a Councilor and a Vice-Councilor shall be elected from District 1, 3, 7 and 10 for a term of one year; a Councilor and a Vice-Councilor shall be elected from Districts 2, 5 and 8 for a term of two years; and a Councilor and a Vice-Councilor from Districts 4, 6 and 9 shall be elected for a term of three years. Following the expiration of these terms, The Councilors and Vice-Councilors shall be elected from each district for a term of three years. No member shall serve the Council for more than two consecutive terms of three years. All officers shall serve until their successors are elected and installed."

SPEAKER KOONCE: There is no motion on the floor. Do I hear a motion that this be adopted?

[A motion was made to adopt the proposed amendment.]

SPEAKER KOONCE: Do you understand that this is a change in the Constitution which will necessitate laying over until

next year. Is there any discussion?

DR. McMILLAN: I would like to say to the members that the reason I did not move the adoption of this amendment is because, you will remember, I told you yesterday, my committee voted not to accept it.

DR. WHARTON [Johnson County]: A matter of clarification, may the Councilors and Vice-Councilors elected for a period of one year then be eligible for two three-year terms? The same thing is applicable to the two-year elections.

SPEAKER KOONCE: Will you answer that, John? The question, I think, is whether the Councilor elected for one year would be eligible to be re-elected one time? Is he a special case? According to the way this resolution is written, he would not.

MR. ANDERSON: It says "No member shall serve as Councilor for more than two consecutive terms of three years."

SPEAKER KOONCE: That is correct. He would be eligible.

DR. PASCHAL: Mr. Speaker and Members of the House of Delegates: I rise to speak against this proposal. It seems to me that our present system has worked well over the years. It has provided an opportunity for the Councilors to have some maturity of thought. It also provides for the removal of those that are not satisfactory to their own constituency.

At the end of a tenure of three years a man is just becoming actually familiar with the responsibilities of his office. He has an opportunity if he succeeds himself to become more familiar with the problems, and at the end of that time is certainly a much more valuable person to each of the members of his district than he was when he first came.

This new proposal certainly seems to me to provide for considerable confusion over several years. It seems also that there would be some ill-feeling developed in some of the districts as to who was going to be selected to have a one-year representation, who was going to be selected to have the two, who was going to be selected to participate in this staggered program. I think that that can be avoided. I think when we reflect on it we will agree that the present system has functioned well and that there has been a fairly good turnover among the Councilors.

A good many of the districts have unwritten laws which have been more or less followed in that no Councilor has succeeded himself or would succeed himself more than once, giving a six-year term. That has been in practice in the Sixth District for a long period of time.

There are a few on the Council who have had longer terms and have been members

for longer periods than just six years.

I do not feel that any county or any district should be penalized by the enactment of this particular phase of our Constitution and Bylaws, which would automatically remove a man of considerable capacity from the Council. I think we can point to the fact that the Tenth District has sent Dr. Sams to our Council for more than two terms, and he has certainly added weight and strength to the Council by his long experience and by his understanding of the problems.

I believe that this unwritten law so to speak will continue to function, and we will continue to get new blood. There has been a considerable change on the Council even since I have been on it.

We need to take the opportunity of nurturing these younger men, urging them to come into the participation in our Council, and I believe what we are doing now certainly serves a useful function and has worked well, and I would advise no change. Thank you, sir! [Applause]

SPEAKER KOONCE: Is there further discussion?

DR. SAMS: Mr. Speaker, I hope I can get across what I wanted to tell you. I have been a member of the Executive Council of the North Carolina Medical Society for thirteen years. I have never missed a meeting.

This proposal to me does two things. It removes the democratic process of running our Society, and then on top of that it comes along and takes the seniority rights entirely away from the Council service.

I cannot see in all the years that I have been connected with the Council that I have ever known a recommendation of theirs to come before this House of Delegates and then be rejected, particularly when it was both the recommendation of the Council and of the Committee.

Your Council on Sunday afternoon went into all the merits and demerits of this proposition, and discussed it thoroughly, and it was a unanimous vote of the Council that we reject this provision for the very same reason that Dr. Paschal has just told you, that our present system has worked well, we have gone along well, and we are in good standing in all the state medical setups of the United States. North Carolina is right up at the top.

Up in my district there are fifteen counties. I don't mind one bit in the world to go out when the boys in that district say that they are tired of me and want me to get out. I don't mind that a bit. But I hate like the devil to be legislated out.

I would, therefore, Mr. Chairman, like

to appeal to you for the better operation of our State Society that we kill this issue here and now because I fear for the long-time results that it might bring to our State Society. I love this State Society. I have given it about fifteen years of my life, and I would hate mighty bad for us to take a backward step. [Applause]

DR. THOMAS DAMERON [Wake County]: I think it is very unfortunate that we interjected a personal aspect into this matter and have not considered it on its own merits. I think all of us realize that Dr. Sams is as fine a gentleman as there is in the state of North Carolina, and we are very proud of him. I would hate for this thing to come up upon the election of one individual, however.

I believe each of the speakers, in speaking against this, has mentioned that there is no need for it because that is what we do anyhow.

If this is the case, then that is all the more reason we should have it written into our laws. Any of us who have worked on Bylaws before know that the reason for having a law is not necessarily to countermand things which are now going on, but to prevent them from happening in the future. I think that is a very good reason for our having it here.

The point about the constitutionality of the thing is a very good one. I think we are all tired of having been dictated against. However, in our own Society we do have rules and regulations which do this to our own advantage, such as the President, who, as you know, cannot succeed himself. I believe we realize it would be very important to have a President to continue in office from year to year. It is a big job, and a person has to learn a great deal. I am sure that the gentlemen who serve as President know more at the end of the year than they did the first of the year, but if we operated on that basis they could continue to succeed themselves indefinitely. There is no need to go into the shortcomings of this system.

I think that if we believe it is good to have change we should keep in mind that we do have several hundred good members of this Society who are capable and who wish to serve and who are not given the opportunity in our present system, and so I think we should vote for this measure.

SPEAKER KOONCE: Is there any further discussion?

DR. PATRICK: This is the same proposal that was given to you yesterday. The only modifications that have been included are to indicate which districts shall have a Councilor on the original representation basis selected for one year, two years or three

years. If you will notice these are scattered equally throughout the state. A man who is elected for one year is eligible to serve for seven years. A man who is elected for two years is eligible to serve for eight years. Of course, the man who is elected for the three-year period on the original setup will not be eligible except for one additional three-year term.

I don't think that this should produce any difficulties with the Districts because this eventually will work itself out, and actually the first two sets have an opportunity to serve seven and eight years rather than six years.

The problem of rotation in the various districts, according to what Mr. Barnes told me last year, is that the Second District has been the only district which has with regularity rotated its Councilors since about 1928 or 1929.

I don't see where this would hurt our Society in any way. I think it will stimulate greater interest and that it will bring more younger men into the activities of the Society.

This is not meant in any way to criticize those men who have been interested in our Society and who have done yeoman work, but they should not carry the entire burden, and there are many men that should be brought in to the affairs of our Society. I believe such a proposal would have this effect.

SPEAKER KOONCE: Is there any further discussion? Are you ready for the question?

DR. FAISON [Charlotte]: Members of the House of Delegates: I agree with the last speaker that this isn't meant to penalize or criticize, but I must say that it does penalize certain men that have experience, that we respect, and I just don't think that we of the Society should oppose the opinion of our Executive Council which studied this thing and of our Committee on Constitution and By-Laws.

As Dr. Paschal has said—and he expressed my feelings exactly—this should remain as it is, and I am very much opposed to any change.

DR. BEST [Clinton]: I move that this be tabled.

SPEAKER KOONCE: There is a motion before the floor and a motion to table takes precedence.

[The motion was seconded.]

SPEAKER KOONCE: A motion has been made and seconded that this be tabled. There is no discussion. All those in favor of tabling this proposal please stand. Please be seated. Gentlemen, all those opposed to

the motion to table this please stand.

There were fifty who voted for the motion to table, forty-eight against. If that motion vote stands, the proposition will be tabled.

[Someone arose to question the count.]

SPEAKER KOONCE: If you question the count, it can be recounted. All those in favor of the motion please stand. Please be seated, gentlemen. All those opposed to tabling this proposition please stand. The vote this time is fifty-five to forty-eight to table the proposition. The Chair rules that the proposition will be tabled.

DR. McMILLAN: Mr. Speaker, Amend Section 1, Chapter I of the By-Laws by deleting the words "Life Members" in line five in order to take care of Article IV of the Constitution. In other words, there is a conflict there. I move the adoption of this amendment, Mr. Speaker.

[The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried ratifying the amendment.]

DR. McMILLAN: On Page 7 of the Constitution—I will have to go back to that again, Mr. Speaker—Section 1, Article VIII, Officers—delete the last sentence, "The foregoing shall constitute the voting members of the Executive Council." (This takes it out of the Constitution, and you vote on the amendment in 1960 and again in 1961.) We passed that the other day.

That Bylaw is on Page 20. Add at the end of Section 1, Chapter IX of the Bylaws, the following: "In the absence of the Councilor at any meeting of the Council, his Vice-Councilor shall perform his duties in his stead." You acted on that on Monday and again on Tuesday of 1960. I move the adoption of this amendment.

[The motion was seconded.]

SPEAKER KOONCE: Are there any questions?

[The motion was put to a vote and carried ratifying the amendment bylaw.]

DR. McMILLAN: Amend Section 9: Chapter XV of the By-Laws by adding thereto the following: "A member of one component Society may also be admitted to membership in another component Society without paying or being included for payment of additional dues to the State Society with the consent of the component Society of the county in which he resides where such additional membership is required for hospital staff privileges."

SPEAKER KOONCE: Do you make such a motion?

DR. McMILLAN: I do move.

[The motion was seconded.]

SPEAKER KOONCE: Are there any questions?

[The motion was put to a vote and carried ratifying the amendment.]

DR. McMILLAN: This is the Constitution again, Mr. Speaker. Amend the Constitution—this is the first reading this afternoon—Article IV, Section 6 as follows: At the end of Section 6, after the word "Journal," insert the following sentence: "If any member eligible for Life Membership elects to continue paying his dues and assessments, he shall then continue as an active member with all active membership privileges including the privileges of holding office and receiving the Journal."

I move the adoption of this amendment.

[The motion was seconded.]

SPEAKERS KOONCE: This is the Constitution now which will not be ratified until next year. Are there any questions?

[The motion was put to a vote and carried.]

SECRETARY RHODES: At the request of Alleghany County, it was shifted from Wilkes to Ashe. That was passed on the first reading yesterday.

SPEAKER KOONCE: Do I hear a motion to accept this as the second reading and to pass it?

[It was so moved. The motion was seconded, was put to a vote and carried ratifying the amendment.]

DR. McMILLAN: That ends our report.

SPEAKER KOONCE: Thank you, Dr. McMillan, for a very difficult job well done.

[At this point there were various announcements and introductions.]

SPEAKER KOONCE: Next on our agenda is the Report of the Committee on Resolutions by Dr. Rhodes.

SECRETARY RHODES: Mr. Speaker, your Reference Committee makes the following report:

(1) Resolution on the death of Dr. Moir S. Martin—The Committee is cognizant of the wide recognition of Dr. Martin for his contributions to medicine and to his community and approve this resolution.

Mr. Speaker, I move the adoption of this portion of the report.

[The motion was seconded, was put to a vote and carried.]

SECRETARY RHODES:

(2) Resolution on Forand-type Congressional Legislation—

The Committee commends the Legislative Committee for authorizing this Resolution. A single change in language is recommended. To obviate possible misconstrued interpretation it is suggested that the word "segregated" at the end of line two (2), paragraph two (2) be re-

placed by the words "large but special."

Mr. Speaker, move the adoption of this portion of the report.

[The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.]

SECRETARY RHODES:

(3) The Resolution relating to the Report of the Ad Hoc Committee on a proposed Retirement Trust Plan incident to possible enactment by Congress of the Jenkins-Keogh bill.

In view of the reported likelihood of congressional adoption of some form of legislation correcting tax inequities for the self-employed—The Committee is complimented for its thorough and efficient work.

The Reference Committee approves this resolution.

Mr. Speaker, I move the adoption of this portion of the report.

[The motion was seconded. Discussion was called for. There being no discussion, the motion was put to a vote and carried.]

SECRETARY RHODES: The final resolution is one which was inadvertently not read yesterday, and I believe you men have a copy and I shall now read this resolution presented by President-Elect, Dr. Amos N. Johnson:

WHEREAS, Article II of the Constitution of the Medical Society of the State of North Carolina which reads:

Article II—Purposes of the Society

The purposes of this Society shall be to federate and bring into one compact organization the medical profession of the State of North Carolina, and to unite with similar organizations in other states to form the American Medical Association with a view to the extension of medical knowledge, and the advancement of medical science; to elevate the standards of medical education and medical service, and to promote friendly intercourse among physicians and to enlighten and inform the people with regard to the great problems of medical care and public health, so that the profession shall become more capable and honorable within itself, and more useful in the prevention and cure of disease, and in prolonging and adding comfort to life.

outlines clearly the purposes of this Society; thereby implying the purposes of its annual session, and

WHEREAS, That portion of Article II dealing with those purposes such as, "The extension of medical knowledge and the advancement of medical science—The prevention and cure of disease and in the prolonging and adding comfort to life"

is now greatly implemented within the framework of this Society by post graduate educational facilities of our three medical schools, by the many medical symposia and seminars conducted within this State, and by the scientific sessions of the many specialty societies existent within this state, and

Whereas, That portion of Article II dealing with those purposes such as "To federate and bring into one compact organization the medical profession of North Carolina—To promote friendly intercourse among physicians, and to enlighten and inform the people with regards to the great problems of medical care and public health, so that the profession shall become more capable and honorable within itself," is deserving of more time and attention at this Society's annual convention, now therefore,

BE IT RESOLVED, That the Annual Convention Commission of this Society be instructed to alter the program format of the Annual Sessions, within the framework of the present Constitution and By-Laws of this Society to produce Annual Session programming containing continuity of thought and of broad scientific spectrum sufficient to be of interest to all doctors of medicine: this not to the exclusion of proper consideration of the the socio-economic aspect of medicine.

The Reference Committee is aware of the poor attendance of the General Sessions in recent years and recognizes the need for an effort to stimulate interest in the General Sessions. The Resolution provides that changes contemplated will be within the framework of the Constitution and By-Laws. The Committee approves this Resolution in principle.

Mr. Speaker, I move the adoption of this portion of the report.

[The motion was seconded.]

[Discussion was called for.]

DR. AMOS JOHNSON: Mr. Speaker, at the time this resolution was written, the framework of Section 2, Article II. Now that is in the process of being deleted, and to avoid the necessity of changing other things next year and confusing Roscoe McMillan further, I would like to delete that word from the resolution which I presented.

SPEAKER KOONCE: Does that meet with the approval of the maker of the motion?

SECRETARY RHODES: I accept that change.

DR. McBRYDE: Does that mean that the sections on the specialties will be abolish-

ed? I think we need a clarification on that.

DR. AMOS JOHNSON: Mr. Speaker and Dr. McBryde: The idea of wording this as loosely as the "resolved" portion is, is so, that mature consideration can be given to this matter. It provides the mechanism to abolish all of the specialty sections program, but within the framework of the present Constitution and By-Laws we would still have the sections, and they would be expected to function should the papers and meetings of the sections, the scientific portion, be deleted. You see, the section officials would still be, in my concept, expected to have a portion of the responsibility of formulating the program for the general sessions.

I would say that it is entirely possible that it might be tried without having sections meeting as they have in the past, but the essayists, the speakers to the general sessions programs, would come from those sections themselves, and the chairman each year elected to the special section would be advisory to the general program committee on scientific sessions. Does that answer your question?

DR. McBRYDE: Yes.

SPEAKER KOONCE: Is there any further question or discussion? Are you ready for the question?

[The motion was put to a vote and carried.]

[A rising vote was taken, which showed that the motion carried overwhelmingly.]

SECRETARY RHODES: Mr. Speaker, this completes the report of the Reference Committee on Resolutions. The report is respectfully submitted by George W. Paschal, Jr., Jacob H. Shuford, and John S. Rhodes.

SPEAKER KOONCE: Thank you, Dr. Rhodes, for a report very well done.

Dr. Schoenheit, will you give your report of the Reference Committee on the President's Report?

DR. SCHOENHEIT: Mr. Speaker, the committee to report on the address of President Reece before the House of Delegates and the first General Session desires to submit the following report.

We heartily approve the revisions that have been made in our Committee structure and of the establishment of our various Commissions. We also feel that the Committee conclave at Pienhurst has been an excellent solution to many problems and has eliminated a considerable amount of travel and expense.

The Public Relations Conference in Pinehurst is an excellent stimulus and should be of increasing value through the years to come.

We are proud of the work of Dr. Reece

and his Committee on Aging and of the fact that North Carolina is well in the lead in this field. We are also in accord with the views of Dr. Reece regarding our Blue Shield Program.

With the increasing number of medical meetings we doubt that an interim clinical session of the Society would be effective and question the wisdom of this venture.

Dr. Reece used good judgment in inviting our delegates of the A.M.A. to attend all meetings of the Executive Council.

Dr. Reece has pointed out that physicians have met the challenge of medicine in each new era and has well stated that we must preserve our heritage of free enterprise; also in our efforts to combat political medicine we are talking the best possible course for the health and welfare of the American people.

We wish to commend Dr. Reece for his two excellent addresses and to thank him for a year of splendid accomplishments under his administration.

Wingate Johnson, M.D.

T. R. Nichols, M.D.

E. W. Schoenheit, M.D.

SPEAKER KOONCE: Do I hear a motion to accept the committee's report?

[Motion to accept the report was made.]

[The motion was seconded, was put to a vote and carried.]

SPEAKER KOONCE: Your Speaker has been very remiss in not recognizing Dr. Schoenheit as Vice Speaker.

I think next year when this Constitution and By-Laws hassle comes around that he can have the Chair, and I am going to stay on the golf course.

There was a resolution presented to the Executive Council, and it was my understanding that that had been taken care of there, but there seems to be some question about it.

Dr. Beddingfield, would you mind letting me know just what the question is?

DR. BEDDINGFIELD: It is simply this, Mr. Speaker—I was approached by the delegation from Harnett County, and asked what had happened to the resolution that they had presented. I don't think they had

been informed. A lot of members of the House of Delegates were interested in the subject matter contained in it.

I think just a word of explanation might be in order.

SPEAKER KOONCE: I don't remember the resolution.

DR. BEDDINGFIELD: The resolution from the Harnett County Society had to do with the dissatisfaction that had been prevalent throughout the state by virtue of certain of our older members who had formerly been granted life membership under our old Constitution and By-Laws, who had been a little upset when their life membership had been taken from them because of the Constitution and By-Laws changes made two years ago which became effective this year.

SPEAKER KOONCE: Dr. Beddingfield, that had been taken care of, we felt, in the Executive Committee. We felt that the action of the Executive Committee would answer that resolution.

DR. BEDDINGFIELD: I think it did, but the people who brought the resolution did not know that.

SPEAKER KOONCE: An interpretation of the By-Laws at the present time is that it cannot be retroactive, except voluntarily. In other words, those people who were life members as of 1959 will remain life members and do not have to pay dues until they wish.

DR. BEDDINGFIELD: Correct me if I am wrong at this point. It is my understanding that any of them who have paid dues under protest, if they insist upon it, can have a refund of what they have paid, but nobody has been thrown out of the Society because of this change.

SPEAKER KOONCE: That is right. There was no change in the Constitution or By-Laws to effect this. It was a question of change in interpretation.

Is there any other business to come before the House? If not, I beg and plead of you just give me a motion to adjourn.

[Upon motion regularly made and seconded, it was voted to adjourn sine die. The House adjourned at three-twenty o'clock.]

ANNUAL REPORTS of OFFICERS, COMMISSIONS, COMMITTEES and BOARDS

REPORT OF THE CONSTITUTIONAL SECRETARY

Membership attendance at the 1959 Annual Meeting in Asheville dropped to 651; a new low for recent years. The decision of the Nominating Committee to recommend Raleigh for the 1960 Annual Meeting should reverse this downward trend. Membership, December 31, 1959, was 3,211 compared with 3,171 for the same date in 1958. This enrollment comprises about three fourths of the registered physicians in the State.

The constitutional amendments relating to Life Members adopted by final action of the 1959 House of Delegates provides that, "Life Members shall consist of those physicians who have been members of the Society consecutively for 20 years and who have attained the age of 70 years . . . (Article IV, Section 6). This action restored to dues paying status former Life Members under age 70. The Executive Council has established a review committee whereby any physician, formerly holding a Life Membership, may be granted exemption from payment of dues, upon his request, based on retirement from practice, disability or hardship.

An innovation in committee planning was inaugurated by President John C. Reece, with a conference of Society officers, Commissioners and committee chairmen in Pinehurst, September 25-27, 1959. Designed to integrate and coordinate committee activities, the conference did

much to eliminate duplication of effort and to motivate committee responsibilities. The fall meeting of the Executive Council was held in conjunction with this conference.

Through cooperation with the State Historical Commission, a marker commemorating the founding of the Medical Society of the State of North Carolina has been placed on the north side of the Capitol Square in Raleigh. The inscription on the marker reads, "Medical Society of North Carolina, successor to earlier group founded in 1799. Formed here in 1849. Dr. Edmund Strudwick was first President".

The Society ended the 1959 fiscal year in sound financial condition. It should be noted that, as determined by the Committee on Finance, 40% of income accruing to the Society is realized through the efforts of the Headquarters Staff; 60% from membership dues. Cramped and inadequate space conditions in the headquarters office have been eased by expansion to occupy the entire second floor of the Capital Club Building in Raleigh.

The secretary wishes to express appreciation to President John C. Reece, all other officers and members of the Society and to Mr. James T. Barnes and personnel of the headquarters office for cheerful and valued help in the conduct of this office.

/s/ John S. Rhodes, M.D.
Secretary

REPORT OF THE EXECUTIVE DIRECTOR MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

Mr. Speaker, President Reece, Members of the House of Delegates, distinguished Guests and Friends . . .

As a long resident of the fair capitol community of Raleigh, I too, welcome you here in your 106th Annual Session—the fourteenth in which I have had some part in the planning or fruition. We at headquarters have worked early, long and late in making the vast detailed preparation for this large assembly of an ever growing membership in this State Medical Society. I am happy to report that the growth is a healthy one, but that the affluence of this body of health serving men of medicine becomes more deeply rooted in the public sense of importance and essentiality. Your opportunities as public servants in medicine and the obligations that follow in such a wake of popular interest and demand can be equaled only in the weight of opportunity and obligation in keeping sound and safe the setting in which you work and bring health and the status of well-being to the people of our state. My tasks for the past year have heavily leaned in the protective direction of such opportunity and obligation which we in headquarters have practiced, also. Whether our combined efforts shall be sufficient to stay the leveling, and sometimes degrading, movements of self-interest and exploitive selfishness which pervades so much of our political and philosophical leadership in this nation I am scarce to predict, but that the fight should be kept in pace with some hope that we see the pendulum of public concern now swinging away from the complete welfare state is, I believe, our continuing mutual duty and our immediate task.

In presenting this report I am due you an accounting for your wide confidence and large assignments. In doing this allow me first to pay tribute to your energetic and forceful President, Doctor John C. Reece. No man has served in this great office that exemplified more ease and grace than has characterized Dr. Reece this year. He has been forceful in meeting all of the obligations of his office and to me he has extended every possible understanding and leadership which makes my job and that of our staff possible. His many kindnesses and his knack for present and determined decision has facilitated his regime and the work of the staff. We wish he would tarry!

I think this has been a significant year. The organization of the Reece regime was accomplished effectively in the late spring weeks of 1959—committees appointed and activated. Almost immediately large tasks devolved upon this Society through the recognition of our leading activity in the programs for the care of the aged and your Society was requested to present this picture to

the Ways and Means Committee of the House of Representatives, 86th Congress, and rush plans entailed developing deputations of content and speakers for hearing appearances in mid July. Our presentations were ably introduced and argued by Doctor John Kernodle joined by a fine deputation on doctors who made contact with our Congressmen. This procedure committed us for continuing duty through the intervening months and we have yet to evaluate the end results, but that the effort was required of us I am sure Dr. Reece never had doubt and his directions were explicit.

Early fall saw the implementation of the new procedure by which the general committee activity of the Society was encouraged by a conclave of meetings with prospectus agenda encompassing a year's program of activities. All appraisals indicate the success of this departure conceived by Dr. Reece and projected at his direction. Work accomplished in comparison to usual progress at that season was marked and without exception evaluations of some hundred and half participating members were reported to favor repeating. Some suggest it might have continuity at the mid-winter officers conference as an adjacent undertaking.

Action by the Medical Society Executives Association (an organization of some 265 State, County and National Medical Executives) placed your Executive Director in the complimentary position of President-Elect and I have shared some increased duty with this national leadership group in the intervening months and will have a larger duty from June 1960 to 1961 when elevated to the position of active President. I must cite this not only as an honor to me but a good reflection on your Society. Moreover, you must bear with me in sparing this duty with those of the State Society.

In the month of January we as a staff staged again a successful mid-winter Officers Conference which was adjudged a remarkable success for bringing adequate orientation to new component society officers, for stimulating state committee work, for inculcating new an emphasized information and philosophy relative to medical programming and medical activity along all fronts of physician activity and concern.

Although this was not a legislative year, much activity has gone apace relative to state affairs and there has been continuous effort on many important matters related to the obligations and concern of the Committee on Legislation. Some of this is staging for the 1961 General Assembly particularly measures which tend to increase assurance of state-right to control and administer certain services related to the health and welfare of the people of the state. As we have reported, national legislation has loomed as a heavy concern and problems for the leadership of the Society. In this President Reece has never faltered in designating deputations to go and do

what was thought necessary to prove the opportunity and obligation of the Society bring affluence and effort to bear on state and national forums where effects would have weight. Reports are in the record of accomplishments on many of these undertakings.

One must observe that the inter-agency and inter-ancillary relationships of the Society have been worked upon at every opportunity during the year and that increasing deference is returning to medicine as a result of these efforts. These are signs of a won affluence in the professional turbulence of our time and one must regard this as progress and a good omen for the future course and concerns of medicine in the socio-economic weights which get involved in medicine in the revolutionary sense in which we inevitably get involved. It is encouraging that all media of information manifests concerns in our field of endeavor and that it is not impossible to get our story of standards and safeguards told in many forums and prints. We shall hope that this can be extended and strengthened in the months and years to come.

As always, we in headquarters have labored as directed in developing your considerations of inner policy and structure and we will have increasing duty and facilitating assignments as you go forward with the implementation of structure and policy. Forbid that we shall ever stand in any than an administrative position on such detail. Use us wherever we may coordinate thought and concern to a point of evaluation and action, but perforce leave us primarily the task of administering that which you have determined and set on course and then give essence to that task by concise and determined direction unwaveringly.

To be sure the years work has been important and interesting as we go into a new decade of work to do and history-in-the-making. It is our sense that our administrative skills and techniques now acquired over near-forty years will have fundamental application as the months and years come and go. In finding that application our sense of your high confidence grows with the tasks assigned and we pledge humble and honest effort and intentions all the way as we understand and perform our duty.

The following constitutes an accounting by incomplete numerical recorded count of many of our efforts:

A. Incoming items of processable mail	20,453
B. Letters, personal and general dispatched	53,074
C. Public Relations Bulletins, dispatched	*26,335
D. Total mail items prepared and dispatched	77,560
E. Telephone communications, local, prepaid and toll	3,040
F. Telegrams, received and dispatched	88
G. Reports, formal, miscellaneous, agenda, transmittals, and memoranda	925

H. Review of literature and reports (interpretive)	900
I. Personal Conferences	684
J. Meetings attended	185
K. Releases to press	549
L. Releases to radio	403
M. Talks made	10

* Additional to item B

There was a gain of membership in 1959 of 40. The total at December 1, 1959 was 3,211. This mark, again, was the highest in the history of the Society.

For the year 1960 the prospects are good; as of April 28, 1960 there were 3,075 members in good standing for the year 1960 as against 3,043 on the approximate same date in 1959—a gain of 32. We had on our mailing list in recent weeks 3,277.

I now have the responsibility under the Finance Committee to perform the function of Treasurer. I know Commissioner, Doctor Wayne Benton, who is also chairman of the Committee on Finance will have apprised you of some of our successes in 1959. It is good to report high increases in exhibit and advertising revenues in ratio the efforts of headquarters staff. Moreover that the fiscal year 1959 showed an overall operating excess of (\$33,866.33) thirty-three thousand eight hundred and sixty-six dollars and thirty-three cents. Of this fact we take some credit and great pride.

Our administration of appropriated allowances we think is recognizably characteristic of sound administration and progressive.

As you will have noted from the Compilation of Reports, both Committees and Commissioners the work of the Society was carried on extensively. The liaison essential to the accomplishment of so much has taken great staff effort, not excepting a growing competence which that staff has acquired. The dispersed arrangements of this annual session program with vast diversifications with scarcely any condition to make it cohesive has been a serious task indeed. Never has so much responsibility for this one course devolved upon us before.

Apace, physician placement goes forward and we think accounts for some of our growth in the Society membership. Rural practice stands at a cross, as indeed may general practice in this state, for lack of appreciation of the difficulties in conducting a practice aside from a proven facility of some magnitude. These are problems for us to recognize in maintaining a level of medical service in all areas and to all people in our state.

For the record, may it be said that the efforts in gaining subscription to advertising and exhibiting space, which together account for a significant margin of resources in financing the operations of the Society, are singularly due to the persistent and historical effort of the staff of headquarters. That responsibility was assigned

by you in 1948 and has had no other contributing source in the years since. It is a plainly assigned and performed duty, but is scarcely performed as a minor effort. It represents "big business". The audit report which constitutes the report of Treasurer, traditionally, is attached and made a part of this report and we request it be considered for formal adoption by the House of Delegates. This report will well reflect the proposition of the management of the Journal. That picture is essentially one of balance for 1959, which, so far as we know the record, is an achievement of the first order.

In conclusion allow us to thank all the Officers and Members of the Society for directions and, especially, for confidences shown during the work year. Personally your estimate of me and my efforts, which are well reflected in the staff too, is a source of great pride on my part. But should any person have a complaint let us beg that he come forward to the official life of the Society that it may be rectified and that the Society and all concerned may grow in strength to serve and to do God's bidding in this great enterprise. For that opportunity, I personally and spiritually acclaim a kind Providence for the strengths of health and mind which has led me this way for a lifetime.

Thank you.

Respectfully submitted,

James T. Barnes

Executive Director

Medical Society of the State of North Carolina
Raleigh, N. C.

April 27, 1960

Attached herewith is the original of the 1959 Audit Report of A. T. Allen & Company of Raleigh, N. C. dated January 26, 1960.

Auditor's Report

Medical Society Of The State Of

North Carolina, Incorporated

Raleigh, North Carolina

12 Months Ended December 31, 1959

Chairman and Members of the Finance Committee
Medical Society of the State of North Carolina, Inc.
Raleigh, North Carolina

Gentlemen:

Pursuant to engagement, we have audited the books and records of the Medical Society of the State of North Carolina, Inc., Raleigh, North Carolina, for the period beginning January 1, 1959, and ending December 31, 1959, and present herewith our report.

Exhibits And Schedules

In presenting to you our findings, as the result of

the audit, we have prepared four Exhibits and four Schedules, as outlined in the Index, which are attached hereto as a part of this report.

Balance Sheet—Exhibit "A":

The first statement is a list of the Assets, Liabilities, Reserves and Net Worth, which we designate as Balance Sheet, December 31, 1959, Exhibit "A". This statement has been divided into two sections. One contains the Current Operating Fund, which represents the Current Assets, Liabilities and Reserves. The other has been designated as a Capital or non-Operating Fund containing the office equipment, real estate, and capital stock owned and used by the Medical Society at estimated values established in a prior year, plus actual cost for purchases during the last ten years.

The Cash on Hand and in Bank is made up of \$50.00 Petty Cash Fund and \$31,780.35 cash in the First-Citizens Bank and Trust Company, Raleigh, North Carolina. The Cash in Bank was verified through a reconciliation of the balances as shown by the records of the Medical Society with a certificate which was obtained independently from the bank. This reconciliation is shown in detail in Schedule—1 of the report.

Accounts Receivable—Regular in the amount of \$1,765.46 are shown on the Balance Sheet and, in the main, represents the total of several uncollected balances due for local advertising in the State Medical Journal. Verifications were forwarded on these accounts and all differences reported were satisfactorily cleared up.

Accounts Receivable—National Advertising in the amount of \$9,383.75 represent November and December, 1959. National Advertising in the State Medical Journal of \$4,428.03 and \$4,955.72, respectively. These amounts were confirmed directly with the State Medical Journal Advertising Bureau. The November amount was received in January, 1960.

Due from the State of North Carolina in the amount of \$105.92 represents overpayments to the State Sales and Use Tax Division in May and June, 1959, of \$123.13. From this amount has been deducted the taxes due the State for the months of July through December, 1959 in the amount of \$17.21, leaving the present balance.

Prepaid Office Supplies in the amount of \$342.33 represent supplies received and on hand at December 31, 1959, but applicable to the operations of the year 1960.

The investment in United States Treasury Notes and in Mutual Fund stocks are shown at cost value of \$54,000.00, in the Balance Sheet, and in detail in Schedule—2 of this report. These securities were examined on January 13, 1960 in the presence of your Executive Director, Mr. James T. Barnes.

The real estate, capital stock, and office equipment and furniture shown on the Balance Sheet in the amount of \$51,300.89 is listed in detail in Schedule—3. This represents an estimate made in a prior year and adjusted for purchases made during the last ten years. The items shown herein represent cost value of the equipment of the Medical Society as no depreciation is recognized. As there were no liabilities outstanding against this equipment, we have shown the entire amount as Net Worth—

Capital Fund—in the Balance Sheet.

Under the "Liabilities" section we have listed those accounts, expenses, etc., incurred prior to December 31, 1959, for which statements or accounts were rendered or for which payment was due.

The Accounts Payable—Trade, in the amount of \$7,708.16 represents unpaid accounts at December 31, 1959. These were confirmed 100% with the creditors by the use of positive verifications. These unpaid accounts are for Journal and Roster publication, \$3,903.69, legal fees, \$3,051.64, and other expense, \$752.83.

The \$1,567.50, Dues to be Refunded, represents State dues collected which are refundable to the members. The \$387.50, "Due American Medical Association", is 1960 A. M. A. dues collected in 1959. The \$287.50, "American Medical Association Dues In Escrow", represents dues paid to the State Society but which cannot be remitted to the National Society at the time due to diverse disqualifying reasons. The pay roll taxes, \$110.86 for the Society's Social Security and \$568.10 for employees' Social Security and Withholding, were paid during the course of the audit. The \$148.39, "Due Hospital Savings Association", represents amount withheld from employees' salaries for hospital insurance during the last quarter of 1959 but unremitted at December 31, 1959.

The deferred credits of \$4,769.50 are for payments of \$3,195.00 received on technical exhibits space at the 1960 Convention, \$874.50 on 1960 Convention Banquet, and \$700.00 on 1960 membership dues. These remittances were received in 1959 and will be transferred to the income accounts in 1960.

The Reserve for Mental Hygiene of \$4,562.83 is a reserve in the process of being built to \$5,000.00 to cover expenses and costs of the said committee in its rehabilitation work. To the balance in this account at January 1, 1959, of \$4,215.03 was added the unexpended Budget Appropriation of \$347.80 in 1959, resulting in the balance at December 31, 1959 of \$4,562.83.

The Reserve for Raymond Randolph Scholarship Fund of \$600.00 represents a reserve for the 1955 Essay Contest Winner, Raymond Randolph, Henderson, North Carolina. This amount is held in escrow for payment to a college which he chooses upon graduation from high school.

The Reserve for Medical Building Site represents the unexpended portion of the \$30,723.00 receipts received from the sale of Series "F" Bonds. The expended portion of this fund was \$26,104.55 and is set out in Schedule—4 of the report. This leaves a balance of \$4,618.45 not disbursed to date.

The "Net Worth" section of the Balance Sheet is comprised of two figures; \$72,099.02 being the balance of the Current Operating Fund for the year; and \$51,300.89 representing the balance of Capital Fund.

Statement of Net Worth—Exhibit "B":

The second statement is an analysis of the changes in Net Worth during the year.

The Current Operating Fund Balance was arrived at by adding to the balance January 1, 1959, of \$35,-

789.22, the amount of Net Income from operations for the current year—\$33,866.33 and Expenditures in 1959 for Capital Fund of \$2,791.27, leaving a balance of \$72,446.82. Then, deducting therefrom the allocation to Reserve for Mental Hygiene Committee, \$347.80, gives the balance at December 31, 1959, of \$72,099.02.

The Capital Fund Net Worth Balance is derived from adding purchases during the year from operating funds for Capital Assets in the amount of \$2,791.27 to the balance January 1, 1959, of \$49,614.83 and deducting therefrom the charge-offs for equipment traded in, \$1,105.21.

Statement of Income And Expenses—Exhibit "C":

A statement showing a budget comparison of the income and expenses for the twelve-month period is shown in Exhibit "C". This statement is, in effect, a statement of operations for the year, and by examination it will be seen that the income of \$221,019.67 exceeded the expenses of \$184,362.07 by \$36,657.60. However, there was included in the expenses \$2,791.27 in Capital Expenditures for Equipment. Eliminating these we show income from operations of \$33,866.33, which has been added to the unexpended balance of the Current Fund and shown in the Net Worth section of the Balance Sheet.

In comparison with the Budget, actual income was more than the Budget anticipated by \$32,469.67. The main items accounting for this are \$19,796.63 more from National Journal Advertising, \$2,948.05 from Local Journal Advertising, \$3,180.00 from Sale of Exhibit space and \$6,161.20 from interest on Government Bonds.

Further examination reveals that the total actual expenses were \$8,828.80 less than the budget provision. The main items accounting for this decrease are \$7,761.10 in Intra Functional Activity Budget and \$6,223.33 in the Public Relations Budget.

Cash Receipts And Disbursements—Exhibit "D":

A statement showing in detail the cash receipts and disbursements of the Society during the year under review is shown in Exhibit "D" which we summarize as follows:

Cash Balance January 1, 1959	\$ 6,189.83
Cash Receipts During The Year	330,461.14
Total Cash Available	\$336,650.97

Less: Disbursements During The Year:

For Operations	\$183,715.98
To A. M. A.—Dues	68,387.50
For Capital Expenditures	2,791.27
Purchase of Mutual	
Fund Stocks	50,000.00
	304,894.75

Cash Balance December 31, 1959	\$ 31,756.22
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We made a careful analysis of the cash transactions and, where practicable, traced the receipts to their original source. Disbursements for expenses were supported by cancelled checks and invoices issued in the regular course of business. We believe the funds have all been accounted for.

General Comments

A surety bond covering faithful performance of Mr. James T. Barnes, Executive Secretary, in the amount of \$50,000.00, is in force, held by the Med-

ical Society and was examined by us. Also in force and examined by us were a Primary Commercial Blanket Honesty Bond in the amount of \$25,000.00; a fire insurance policy, with 80% co-insurance clause, covering fire loss on office equipment, books and records in the office of the Executive Secretary, Raleigh, North Carolina, in the amount of \$2,500.00; an Automobile Schedule Liability Policy; a Standard Workmen's Compensation and Employer's Liability Policy; and a Comprehensive General Liability Policy.

As noted under Miscellaneous Budget—Employees' Retirement System (G-11), payments of \$2,939.88 on the Pension Plan of the Society were made during the current year to Penn Mutual Life Insurance Company. At December 31, 1959, there were three employees eligible and covered under this plan. The plan became effective October 15, 1957 for employees who are full time permanent employees between the ages of twenty-five and fifty-five and have three years of continuous service if employed before October 15, 1957, or four years of continuous service if employed after October 15, 1957.

We were extended every courtesy and cooperation during the course of the audit; and we experienced no trouble in making our audit and obtaining the necessary information for this report.

Scope of Examination And Opinion

We have examined the balance sheet of the Medical Society of the State of North Carolina, Incorporated, as of December 31, 1959 and the related statements of income and expense and net worth for the year then ended. Our examination was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the accompanying balance sheet and statements of income and expense and net worth present fairly the financial position of the Medical Society of the State of North Carolina, Incorporated, at December 31, 1959, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles for non-profit organizations applied on a basis consistent with that of the preceding year.

Very truly yours,

A. T. ALLEN & COMPANY
CERTIFIED PUBLIC ACCOUNTANTS
By: A. T. Allen.
Certified Public Accountant

(SEAL)
Raleigh, N. C.
January 26, 1960
Medical Society of the State of North Carolina, Inc.

Raleigh, North Carolina

INDEX

Exhibits

Balance Sheet Exhibit "A"

Statement of Net Worth Exhibit "B"
Statement of Income and Expenses Exhibit "C"
Cash Receipts and Disbursements Exhibit "D"

Schedules

Cash On Hand And In Bank Schedule—1
Investment in United States Bonds Schedule—2
Schedule of Capital Assets Schedule—3
Schedule of Building Site Costs Schedule—4

EXHIBIT "A"—BALANCE SHEET

December 31, 1959

ASSETS

CURRENT OPERATING FUND:
Cash On Hand And In Bank—(Schedule—1) \$ 31,830.35
Accounts Receivable—Regular 1,765.46
Accounts Receivable—National Advertising 9,383.75
Due From State of North Carolina (Overpayment of Sales Tax) 105.92
Prepaid Supplies 342.33
Investment in Treasury Bonds and Mutual Fund Stocks 54,000.00
TOTAL CURRENT OPERATING FUND \$ 97,427.81

CAPITAL OR NON-OPERATING FUND—(SCHEDULE—3)

Real Estate \$ 26,104.55
Office Furniture and Fixtures 24,946.34
Capital Stock, Common—State Medical Journal
Advertising Bureau 200.00
TOTAL CAPITAL OR NON-OPERATING FUND 51,300.89
TOTAL ASSETS \$ 148,728.70

LIABILITIES, RESERVES AND NET WORTH

LIABILITIES:
Accounts Payable—Trade \$ 7,708.16
Dues To Be Refunded 1,567.50
Due American Medical Association 387.50
Due American Medical Association
—Dues in Escrow 287.50
Federal Income Taxes Withheld 568.10
Pay Roll Taxes Payable 110.86
Due Hospital Savings Association 148.39
TOTAL LIABILITIES \$ 10,778.01

DEFERRED CREDITS:

Advance Payments On Technical Exhibit Space At 1960 Convention \$ 3,195.00
Advance Payments On 1960 Convention Banquet 874.50
Advance Payments On 1960 Membership Dues 700.00
TOTAL DEFERRED CREDITS 4,769.50

RESERVES:

Reserve For Mental Hygiene Committee \$ 4,562.83
Reserve For Payment Randolph Scholarship Fund 600.00
Reserve For Medical Building Site 4,618.45
TOTAL RESERVES 9,781.28

NET WORTH:

Current Operating Fund—(Exhibit "B") \$ 72,099.02
Capital Fund (Exhibit "B") 51,300.89
TOTAL NET WORTH 123,399.91
TOTAL LIABILITIES, RESERVES AND NET WORTH \$ 148,728.70

EXHIBIT "B"—STATEMENT OF NET WORTH

12 Months Ending December 31, 1959

CURRENT OPERATING FUND:
Balance January 1, 1959 \$ 35,789.22
ADD:
Net Income From Operations—
Exhibit "C" \$ 33,866.33
Expenditures for Capital Fund 2,791.27
Total \$ 72,446.82
LESS:
Allocation to Reserve for Mental Hygiene 347.80
**TOTAL CURRENT OPERATING FUND—
TO EXHIBIT "A"** \$ 72,099.02

CAPITAL FUND:

Balance January 1, 1959 \$ 49,614.83
ADD:
Purchases Made Through Current Fund 2,791.27
Total \$ 52,406.10

LESS:

Charge-Offs For Office Furniture and Fixtures Traded In 1,105.21
TOTAL CAPITAL FUND—TO EXHIBIT "A" 51,300.89
TOTAL NET WORTH—DECEMBER 31, 1959 \$ 123,399.91

EXHIBIT "C"—STATEMENT OF INCOME AND EXPENSES

12 Months Ended December 31, 1959

	Budget Provision	Actual	Difference
INCOME:			
Membership Dues—Current			
and Prior Years	\$132,500.00	\$133,413.00	\$ 913.00

SUPPLEMENT — TRANSACTIONS, 1960

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Interest on Government Bonds	275.00	6,436.20	6,161.20
Sale of Exhibit Space	13,000.00	16,180.00	3,180.00
Journal Advertising—Local	4,000.00	6,948.05	2,948.05
Journal Advertising—National	32,000.00	51,796.63	19,796.63
Journal Subscriptions	800.00	1,528.19	728.19
Sale of Rosters			
Author's Contributions			
to Cost of Cuts	300.00	95.55	(204.45)
Commission (1%) From A. M. A.			
for Dues Collected	625.00	680.75	55.75
Revenue Unexpected	1,200.00	899.30	(300.70)
Ticket Sales—1959			
Convention Banquet	3,850.00	3,042.00	(808.00)
TOTAL INCOME	\$188,550.00	\$221,019.67	\$ 32,469.67
EXPENSES:			
Executive Budget:			
A-1 Expense—President	\$ 3,000.00	\$ 1,838.81	\$ 1,161.19
A-2 Salary—Secretary	-0-	-0-	-0-
A-3 Travel—Secretary	600.00	246.11	353.89
A-4 Salary—Executive Director	10,900.00	10,900.00	-0-
A-5 Travel—Executive Director	3,100.00	3,100.53	(.53)
A-6 Clerical Assistants—Office	13,000.00	16,843.81	(1,843.81)
A-7 Equipment—Office	1,000.00	1,476.91	(476.91)
A-8 Expenses—Office	6,000.00	5,954.25	45.75
A-9 Bonding	-0-	10.00	(10.00)
A-10 Auditing	600.00	967.00	(367.00)
A-11 Payroll Taxes	495.00	538.94	(43.94)
A-12 Insurance	165.00	188.93	(23.93)
A-13 Membership Record System	-0-	-0-	-0-
A-14 Publications, Reports and			
Executive Aids	100.00	115.38	(15.38)
A-15 Insurable Interest Insurance	1,371.00	1,370.80	.20
Miscellaneous—Cash			
Unaccounted For	-0-	6.18	(6.18)
Total Executive Budget	\$42,331.00	\$43,559.65	(\$ 1,228.65)
Journal Budget:			
B-1 Publication of Journal	\$39,000.00	\$47,322.00	(\$ 8,322.00)
B-2 Cuts for Journal	675.00	394.90	280.10
B-3 Salary—Editor	2,310.00	2,310.00	-0-
B-4 Salary—Assistant Editor	3,600.00	3,600.00	-0-
B-5 Expenses—Editorial Office	400.00	302.20	97.80
B-6 Expenses—Business			
Manager's Office	300.00	168.01	131.99
B-7 Equipment—Business			
Manager's Office	200.00	153.83	46.17
B-8 Travel For Journal	200.00	-0-	200.00
B-9 Payroll Taxes	148.00	147.73	.27
B-10 Refunds, Subscriptions, Etc.	30.00	-0-	30.00
B-11 Publication of Roster	3,000.00	5,506.49	(2,506.49)
B-12 Sales Tax on Journal and			
Roster Sales	475.00	403.18	71.82
B-13 Transactions	3,000.00	-0-	3,000.00
Total Journal Budget	\$53,338.00	\$60,308.34	(\$ 6,970.34)
Intra-Functional Activity Budget:			
C-1 Expenses—Executive Council	\$ 2,500.00	\$ 1,263.41	\$ 1,236.59
C-2 Expenses—Councilors	500.00	2.76	497.24
C-3 Expenses—Legislative			
Committee	1,500.00	1,519.61	(19.61)
C-4 Expenses—Maternal			
Health Committee	2,800.00	2,730.00	70.00
C-5 Expenses—Cancer Committee	-0-	.30	(.30)
C-6 Expenses—Convention Arrange-			
ments Committee	-0-	-0-	-0-
C-7 Expenses—Scientific Exhibits			
Committee	75.00	226.97	(151.97)
C-8 Expenses—Mental Health			
Committee	500.00	152.20	347.80
C-9 Expenses—Grievances			
Committee	(See E-18)	-0-	-0-
C-10 Expenses—Chronic Illness			
Committee	750.00	483.58	266.42
C-11 Expenses—Committees			
in General	2,000.00	2,990.43	(990.43)
C-12 Expenses—Anesthesia			
Study Committee	400.00	390.00	10.00
C-13 Expenses—Occupational			
Health Committee	320.00	23.00	297.00
C-14 Expenses—Professional Liability			
Insurance Committee	-0-	37.97	(37.97)
C-15 Expenses—Child Health	1,000.00	844.78	155.22
C-16 Expenses—Negotiations			
Committee	6,000.00	457.09	5,542.91
C-16-B Equipment		261.12	
C-17 Expenses—Student			
A. M. A. Committee	905.00	568.00	337.00
C-18 Expenses—Military and Emergency			
Medical Service Committee	305.00	147.68	157.32
C-19 Expenses—Industrial			
Commission Committee	305.00	-0-	305.00
Total Intra-Functional			
Activity Budget	\$19,860.00	\$12,098.90	\$ 7,761.10
Extra-Functional Activities Budget:			
D-1 Expense of A. M. A.			
Delegates	\$ 1,500.00	\$ 1,490.61	\$ 9.39
D-2 Conference Dues	200.00	172.00	28.00
D-3 Woman's Auxiliary	950.00	1,208.77	(258.77)
D-4 Expenses of Delegates—A. M. A.			
Regional Conference	300.00	-0-	300.00
D-5 Expense of S. A. M. A.			
Delegates	500.00	441.54	58.46
Total Extra-Functional			
Activities Budget	\$ 3,450.00	\$ 3,312.92	\$ 137.08
Public Relations Budget:			
F-1 Salary—Assistant for			
Public Relations	\$ 8,855.00	\$ 8,855.00	\$ -0-
F-2 Travel—Assistant for			
Public Relations	1,800.00	1,631.02	168.98
F-3 Travel—Committee			
Chairman	300.00	134.13	165.87
F-4 Clerical Assistant—Office	2,500.00	2,550.00	(50.00)
F-5 Equipment—Office	1,000.00	292.02	707.98
F-6 Expense—Office	3,000.00	2,940.15	59.85
F-7 Taxes—Payroll	175.00	183.75	(8.75)
F-8 Publications and			
Executive Aids	150.00	76.66	73.34
F-9 Audio-Visual Depiction	500.00	134.61	365.39
F-10 Educational Distributions	400.00	479.64	(79.64)
F-11 News and Press Releases	600.00	71.89	528.11
F-12 Public Relations Bulletin	2,300.00	1,133.47	1,166.53
F-13 School Physicians Conference	250.00	33.07	216.93
F-14 Exhibits and Displays	650.00	618.33	31.67
F-15 Medical Students Conference	1,000.00	604.39	395.61
F-16 Physicians Press Conference	400.00	-0-	400.00
F-17 Public and Personified			
Activities	800.00	528.93	271.07
F-18 Collateral Public Relations	2,000.00	189.61	1,810.39
Total Public Relations Budget:	\$26,680.00	\$20,456.67	\$ 6,223.33
Annual Sessions (105th) Convention Budget:			
F-1 Programs	\$ 1,700.00	\$ 1,668.85	\$ 31.15
F-2 Hotel and Auditorium			
Expense	2,500.00	2,102.34	397.66
F-3 Expenses—Publicity			
Promotion	300.00	242.88	57.12
F-4 Entertainment	775.00	726.92	48.08
F-5 Orchestra and Floor			
Entertainment	2,500.00	1,959.07	540.93
F-6 Guest Speakers	800.00	617.77	182.23
F-7 Banquet Speaker	-0-	-0-	-0-
F-8 Electric Amplifications	350.00	175.00	175.00
F-9 Booth Installations and			
Supplies	4,000.00	5,308.03	(1,308.03)
F-10 Projection Expense	500.00	381.26	118.74
F-11 Badges	150.00	96.99	53.01
F-12A Transactions Reporting			
Service)	2,000.00	858.84	542.59
F-12B Reporting Equipment)		598.56	
F-13 Rental—Extra Facilities	400.00	192.51	207.49
F-14 Exhibitors Entertainment	1,100.00	596.64	503.36
F-15 Banquet Expense	5,000.00	3,331.75	1,668.25
Total Annual Sessions (105th)			
Convention Budget	\$22,075.00	\$18,857.42	\$ 3,217.58
Miscellaneous Budget:			
G-1 Previous Accounts Payable	\$ 100.00	\$ -0-	\$ 100.00
G-2 Refunds	100.00	-0-	100.00
G-3 Legal Counsel	7,500.00	8,310.23	(810.23)
G-4 Reporting (Executive			
Council, Etc.)	1,200.00	1,150.71	49.29
G-5 President's Jewel	1,160.00	1,066.70	93.30
G-6 Awards—General Practitioners			
of Year	60.00	18.34	41.66
G-7 Fifty Year Club	50.00	8.40	41.60
G-8 Sections (12) Expense	100.00	56.13	43.87
G-9 Contingency and Emergency	1,000.00	823.08	176.92
G-10 Organization Survey	-0-	-0-	-0-
G-11 Employees' Retirement System	2,300.00	2,939.88	(639.88)
Total Miscellaneous Budget	\$13,570.00	\$14,373.47	(\$ 803.47)
Rural Health Function Budget:			
H-1 Expense—Committee			
Chairman	\$ 300.00	\$ 146.07	\$ 153.93
H-2 Salary—Rural Health			
Consultant	6,006.00	6,006.00	-0-
H-3 Travel—Rural Health			
Consultant	2,000.00	1,904.32	95.68
H-4 Clerical Assistant—			
Part Time	1,302.00	1,348.31	(46.31)
H-5 Taxes—Payroll	153.00	158.47	(5.47)
H-6 Rural Health Conferences	600.00	150.74	449.26
H-7 Office Expenses	700.00	1,274.51	(574.51)
H-8 4-H Club Activities	400.00	406.28	(6.28)
H-9 Education Displays	450.00	-0-	450.00
Total Rural Health			
Function Budget	\$11,911.00	\$11,394.70	\$ 516.30
TOTAL EXPENSES	\$193,215.00	\$184,362.07	\$ 8,852.93
SUMMARY:			
TOTAL INCOME			\$221,019.67
LESS: EXPENSES:			
Executive Budget		\$ 43,559.65	
Journal Budget		60,308.34	
Intra-Functional Activity Budget		12,098.90	
Extra-Functional Activity Budget		3,312.92	
Public Relations Budget		20,456.67	
Annual Sessions (105th) Convention Budget		18,857.42	
Miscellaneous Budget		14,373.47	
Rural Health Function Budget		11,394.70	\$184,362.07
EXCESS OF INCOME OVER EXPENSES			\$ 36,657.60
LESS: CAPITAL EXPENDITURES			
FROM CURRENT FUNDS			2,791.27

NET INCOME FROM OPERATIONS—
TO EXHIBIT "B" \$ 33,866.33

EXHIBIT "D"

CASH RECEIPTS AND DISBURSEMENTS

12 Months Ended December 31, 1959

RECEIPTS:

CASH RECEIVED FROM REGULAR OPERATIONS:	
Members' Dues—Current And Prior Years	\$133,388.00
Medical Journal Advertising—Local	7,685.31
Medical Journal Advertising—National	49,888.66
Sale of Exhibit Space at 1959 Convention	12,775.00
Sale of Exhibit Space at 1960 Convention	3,195.00
Medical Journal Subscriptions And Sale	406.65
Sales of Rosters	652.48
Interest on United States Government Bonds	7,436.20
Commissions (1%) From AMA For	
Collecting Dues	680.75
Over-Collection of Dues—	
Later Refunded	2,149.00
Miscellaneous Refunds	21.87
Miscellaneous Income	1,110.72
TOTAL CASH RECEIVED FROM REGULAR OPERATIONS	\$219,389.64
AMERICAN MEDICAL ASSOCIATION—	
REGULAR DUES COLLECTED	68,500.00
RECEIPTS FROM UNITED STATES BONDS—	
PRINCIPAL	39,368.00
RECEIPTS FROM 1959	
CONVENTION BANQUET	2,216.50
RECEIPTS FROM 1960	
CONVENTION BANQUET	874.50
AMERICAN MEDICAL ASSOCIATION	
DUES IN ESCROW	112.50
TOTAL RECEIPTS	\$330,461.14
CASH BALANCE, JANUARY 1, 1959:	
First Citizens Bank & Trust Co.,	
Raleigh, N. C.	\$ 5,195.05
Cash on Hand	994.78
TOTAL TO ACCOUNT FOR	\$336,650.97

DISBURSEMENTS:

DISBURSEMENTS FOR CURRENT OPERATIONS:	
Expenditures—Executive Budget	\$ 43,763.89
Less: Capital Expenditures—	
Office Equipment	1,476.91
Expenditures—Journal Budget	\$ 60,440.14
Less: Capital Expenditures—	
Office Equipment	153.83
Expenditures—Intra-Functional	
Activity Budget	\$ 12,141.44
Less: Capital Expenditures—	
Office Equipment	261.12
Expenditures—Extra-Functional	
Activities Budget	3,312.92
Expenditures—Public Relations Budget	\$ 20,560.28
Less: Capital Expenditures—	
Office Equipment	292.02
Expenditures—Annual Sessions (105th)	
Convention Budget	\$ 18,851.08
Less: Capital Expenditures—	
Office Equipment	598.56
Expenditures—Miscellaneous Budget	14,961.33
Expenditures—Rural Health	
Function Budget	\$ 11,464.21
Less: Capital Expenditures—	
Office Equipment	8.83
Refunds of Dues Over-Collected	971.50
Refunds of AMA Dues in Escrow	50.00
Refunds—Miscellaneous	152.83
Returned Checks—Written Off as	
Uncollectible at 12-31-59	2.06
Accrued Pay Roll Taxes—12-31-58	578.59
Accrued Hospital Insurance—12-31-58	28.90
TOTAL	\$184,487.90
LESS: Deductions From Wages—Unpaid	
at 12-31-59:	
Pay Roll Taxes	\$ 623.53
Hospital Insurance	148.39
TOTAL DISBURSEMENTS FOR CURRENT OPERATIONS	\$183,715.98
PAYMENTS TO AMERICAN MEDICAL ASSO-	
CATION—REGULAR DUES COLLECTED	68,387.50
EXPENDITURES FOR CAPITAL ASSETS	2,791.27
PURCHASE OF MUTUAL FUND STOCKS	50,000.00
TOTAL DISBURSEMENTS	\$304,894.75
CASH BALANCE, DECEMBER 31, 1959:	
First Citizens Bank & Trust Co.,	
Raleigh, N. C.	31,756.22
TOTAL ACCOUNTED FOR	\$336,650.97

SCHEDULE—1

CASH ON HAND AND IN BANK

December 31, 1959

FIRST-CITIZENS BANK AND TRUST COMPANY,
RALEIGH, N. C.:

Balance Per Bank Statement \$ 25,292.80

Deposits Entered to Wrong Account in Error
By Bank, Bank Credit Memo Received
January 7, 1960.

12-9-59	\$ 5,435.31	
12-15-59	251.67	
12-21-59	1,336.72	7,023.70
Total		\$ 32,316.50
LESS: Outstanding Checks:		
Number 8303	\$ 243.35	
8319	7.50	
8323	9.50	
8333	150.80	
8351	125.00	536.15
BALANCE PER BOOKS		\$ 31,780.35
PETTY CASH FUND		50.00
TOTAL CASH—TO EXHIBIT "A"		\$ 31,830.35

SCHEDULE—2

INVESTMENTS IN SECURITIES

December 31, 1959

	Date of Issue	Date of Maturity	Par Value At Maturity	Cost
3-1/2% TREASURY NOTES—SERIES A-1960:				
Number 8442	2-15-57	5-15-60	\$ 1,000.00	\$ 1,000.00
8443	2-15-57	5-15-60	1,000.00	\$ 1,000.00
8444	2-15-57	5-15-60	1,000.00	\$ 1,000.00
8445	2-15-57	5-15-60	1,000.00	\$ 1,000.00
TOTAL TREASURY NOTES			\$ 4,000.00	\$ 4,000.00
INVESTORS MUTUAL, INC. STOCK:				
4,677.268 Shares—(Investors				
Mutual, Inc. is Holding Certificate.)				50,000.00
TOTAL INVESTMENTS IN SECURITIES—TO EXHIBIT "A"				\$54,000.00

SCHEDULE—3

SCHEDULE OF CAPITAL ASSETS

December 31, 1959

OFFICE FURNITURE AND FIXTURES:
EXECUTIVE OFFICE:

Wooden File Case—Letter Size	\$ 21.66
Typewriter Desk	25.00
Steel Office Safe	150.00
Steel File Case—Letter Size	20.00
Four Steel Card Files	20.00
Office Chair	35.20
One Desk	62.55
Steel Filing Cabinet	24.50
Office Desk	47.95
Letter File—Two Drawer	29.46
Steel Filing Cabinet	71.75
Office Chairs	40.00
Office Desk	87.29
Office Equipment—Miscellaneous	1,149.39
One (1) Telephone Table—Wooden	15.45
Two Pairs 12" x 38" C. S. Vents and Brackets	8.77
One (1) Desk Lamp	10.26
Two (2) Master Model Audiographs and	
Attachments	725.67
One (1) Map of Greater Carolinas	37.50
Two (2) Double Files 3" x 5"	11.86
One (1) Remington Electric Deluxe Typewriter	337.90
Three (3) Pendaflex Frames (Installed)	5.57
Two (2) Gray Steel Cabinets	103.00
Three (3) Transfer Files	11.89
One (1) Spec. D. Outfit File	7.25
Two (2) Legal Filing Cabinets	19.90
One (1) Filing Shelf	2.50
Plywood Carrying Case for Audiograph	17.00
Map Framed	3.61
Charter Framed	2.57
Cash Box	2.79
Steel Desk	158.98
Three (3) Desk Trays With Stackers	8.57
Waste Basket	1.40
Large Chair Mat	9.27
Glass Desk Top	11.68
Stenograph and Tripod	100.70
Four Drawer Steel Filing Cabinet	78.03
Four Pendaflex Steel Frames (Installed)	7.42
Postal Scale	6.50
Numbering Machine	14.88
Filing Stool	11.23
Bookcase	63.86
Remington Rand Electric Adding Machine	215.01
Metal Storage Cabinet	78.28
Metal Filing Cabinet	92.76
Two (2) Cabinet Shelves (Installed)	10.30
Metal Cash Box	2.32
Pro Rata Share of Cost of Mimeograph Machine	337.47
Typewriter Table	21.00
Metal Correspondence Separator	6.18
Metal File and Sections	68.55
Two (2) Typewriters—Large Type (Bulletin)	321.23
Kardex File and Parts	1,842.36
Catalogue Case	20.00
Metal File and Frames	93.07
Electric Typewriter	477.00

Secretarial Foot Control	25.75	Metal File	95.79
Three (3) Transfer Files	16.23	Pro Rata Share of Cost—Vartypewriter—Used ..	50.00
Junior Pendaflex File	22.87	Pro Rata Share of Cost—A. B. Dick Offset	
Book Case Section	26.25	Duplicator	1,602.26
Remington Electric Typewriter	290.30	Pro Rata Portion of Postage Mailing Machine ..	427.85
Swivel Chair and Arm Chair	74.48	Pro Rata Portion of Robotypewriter	360.50
Audiograph Converter	28.84	Pro Rata Portion of Perforator	121.02
Pendaflex File	5.88	Pro Rata Portion of One (1) Table	17.58
Used Desk and (2) Files	281.43	Pro Rata Portion of Postal Scale	12.47
De Jur Camera With Flash Attachment and		Stenorette Machine #205817	205.06
Case	100.44	Pro Rata Portion of Used Addressograph	
Audiograph Machine—Used	300.00	Machine #312185 With Work Table	75.00
Flight Bag	38.31	Pro Rata Portion of Hand Truck	3.13
Three (3) Box Files	9.42	Pro Rata Portion of Two Ginger Valets—	
Portable Lectern	29.93	#V-6-U	8.83
Metal File	114.33	TOTAL PUBLIC RELATIONS OFFICE	\$ 6,336.93
Checkwriter—Paymaster	101.48	JOURNAL BUSINESS MANAGER'S OFFICE:	
Desk and Chair	268.45	Steel File and Frame	\$ 88.27
Supply Cabinet Shelves	25.35	Pro Rata Share of Cost of Imperial Safe	
Pro Rata Share of Cost of Imperial Safe		KD "60" (Kardex)	170.77
KD "60" (Kardex)	290.00	Book—"Successful Sales Promotion"	5.65
Air Conditioning Equipment—Office	1,621.00	Pro Rata Portion of Remington Electric	
Five Drawer Letter File and Frames	122.78	Typewriter #2129420	153.83
Five (5) Transfer Files	20.35	TOTAL JOURNAL BUSINESS MANAGER'S	
Two (2) Five Drawer Filing Cabinets	245.56	OFFICE	\$ 418.52
American Medical Dictionary	25.00	RURAL HEALTH AND MEDICAL CARE COMMITTEE:	
Two (2) Plate Glass Tops for Desks	20.34	Masco Tape Recorder	\$ 159.18
Desk, Swivel Chair and Desk Set	253.87	One (1) Desk	185.40
Remington Rand Electric Typewriter	430.55	One (1) Steel File and Trays	121.29
Pro Rata Share of Cost—Vartypewriter—Used	50.00	One (1) Soundscraper	150.00
Pro Rata Share of Cost—A. B. Dick Offset		Pro Rata Portion of Two Ginger Valets—	
Duplicator	1,602.27	#V-6-U	8.83
Ten (10) Pronto Files	46.87	TOTAL RURAL HEALTH AND MEDICAL	
Two (2) Four Drawer Durable File Cabinets ..	61.70	CARE COMMITTEE	624.70
One (1) Kardex File Safe and Base	593.28	ANNUAL SESSIONS CONVENTION:	
Pro Rata Portion of Postage Mailing Machine ..	427.85	Portable Lectern	\$ 29.67
Pro Rata Portion of Robotypewriter	360.50	Stenorette Machine #219618	205.06
Pro Rata Portion of Perforator	121.03	Stenorette Machine #214740	196.75
Pro Rata Portion of One (1) Table	18.47	Stenorette Machine #216837	196.75
Pro Rata Portion of Postal Scale	12.48	TOTAL ANNUAL SESSIONS CONVENTION	628.23
Stenorette Machine #215391	156.06	INTRA FUNCTIONAL ACTIVITIES:	
Stenorette Machine #219890	156.06	Gray Secretary's Desk	\$ 224.35
Two Transcribing Kits For Stenorettes	60.08	Gray Secretary's Chair	36.77
Telephone Adapter and Switch Box	17.66	TOTAL INTRA FUNCTIONAL ACTIVITIES	261.12
Two Gray Legal Desk Trays	14.63	TOTAL OFFICE FURNITURE AND FIXTURES	\$ 24,996.34
Book Case Section #813 Walnut	29.26	REAL ESTATE:	
Gray Table #1808	49.59	Land—Durham-Raleigh Highway—(Schedule—4)	26,104.55
Three Transcribing Kits For Stenorettes	89.75	OTHER ASSETS:	
Four Stetho Clips For Stenorettes	12.00	Capital Stock—State Medical Journal Advertising	
Documentor Electric Typewriter	272.55	Bureau, Inc.	200.00
Remington Electric Typewriter #E-2289256 ..	360.85	TOTAL CAPITAL ASSETS—TO EXHIBIT "A"	\$ 51,300.89
Pro Rata Portion of Used Addressograph Machine		SCHEDULE—4	
#312185 With Work Table	75.00	SCHEDULE OF BUILDING SITE COSTS	
Pro Rata Portion of Hand Truck	3.00	12 Months Ended December 31, 1959	
Pro Rata Portion of Two Ginger Valets	26.59	Options	\$ 450.00
#V-6-U		Land Purchase—Durham-Raleigh Highway	24,650.00
Pro Rata Portion of Remington Electric		Legal Service	126.75
Typewriter #2129420	153.83	Survey and Map of Property	477.80
TOTAL EXECUTIVE OFFICE	\$ 16,726.84	Architect Service	400.00
PUBLIC RELATIONS OFFICE:		TOTAL TO SCHEDULE 3	\$26,104.55
Four (4) Aluminum Desk Trays With Supports \$	9.00	FIRST MEDICAL DISTRICT	
Steel Costumer	14.20	The First Medical District has had no problems	
Cash Box	1.50	requiring the intervention or guidance of the	
Supply Cabinet	37.00	Councilor.	
Two (2) Waste Baskets	7.00	The component medical societies have function-	
Metal Executive Desk	112.60	ed well and all problems have been handled at	
Executive Chair	48.80	the local level.	
Two (2) Side Arm Chairs	60.40	In the field of post-graduate education, we have	
Metal Secretary Desk	136.40	finished an excellent six lectures sponsored by	
Secretary Chair	30.20	the U. N. C. Extension Division and last June, a	
Storage Cabinet	37.00	fine meeting by the Seaboard Medical Association	
Two (2) Chair Mats	12.90	was held at the Carolinian, Nags Head, N. C. Our	
Hinge Top Card File	1.60	district is happy that this meeting will be held	
Stapler	4.95	again at the same place June 17th, 18th, and 19th	
Punch	3.15	with a very good program in prospect.	
Metal Letter File With Lock	61.60	Our District Society Meetings have been well	
Storage Cabinet	37.00		
Royal Typewriter	133.31		
Two (2) Electric Fans	63.29		
Four Drawer Metal File	69.49		
Two Drawer Metal File With Lock and Base ..	18.36		
Supply Cabinet	75.00		
Two (2) Desk Trays and Stacks	4.64		
Metal Storage Cabinet	57.29		
Pro Rata Share of Cost of Mimeograph			
Machine	508.53		
Pendaflex Frames (Installed)	4.64		
Folder Machine and A. B. Dick Stand	397.88		
Used Elliott Addressograph	123.83		
Two (2) Telephone List Finders	6.06		
Pendaflex Frame (Installed)	4.50		
Verifax Printer Type I	247.20		
Used Projector—Nadco	153.43		
Model DLS Screen	32.45		
Record Player	101.25		
Microphone and Stand	19.40		
Projector With Case—Slide	94.47		
Lectern Mike	56.85		
Display Equipment—Flip Chart	31.74		
Remington Electric Typewriter	430.55		
One (1) Camera and Flash	88.98		
Film Holders and Adapters	19.00		

attended and instructive.

/s/ T. P. Brinn, M.D., Councilor
First District

SECOND MEDICAL DISTRICT

The 2nd District of the State Medical Society has had no serious major problems during the several months that I have been Councilor. The component County Societies have met regularly and handled their problems satisfactorily. Currently pending is one problem of a person, apparently who is not a physician, attempting to carry out what constitutes medical practice without a license. This matter will be handled when further evidence is available.

The 2nd District held its regular meeting at the Governor Tryon Hotel in New Bern on December 2, 1959. Dr. Charles Ashford and Dr. L. H. Erdman, the President and Secretary respectively, made the necessary arrangements, and a very fine meeting was held. A scientific session was furnished by members of the faculty of Bowman Gray and the University of N. C. A distracting feature was the lack of attendance that should be present at such meetings. This leads me to feel that participation by physicians in their local and district medical affairs should continue to be emphasized. As Councilor for this district, I advised that written minutes and financial records be kept of the 2nd District affairs, which was implemented at this meeting by a vote of those present. The district was also given the idea of meeting either quarterly or twice yearly, and it was decided that this would be considered by the new officers as a possibility for the future. The new officers of the 2nd District are, Dr. W. M. Brady and Dr. Sam Hatcher of Morehead City, President and Secretary respectively. They plan to call the next meeting in the Morehead City vicinity, at a time and place to be designated later.

There has been some apparent inertia among many physicians in this District regarding medicine's opposition to third party intervention, continued increasing governments social legislation, and other enemies of Private Medical Practice as we know it. I feel that continued attempts to arouse physicians to speak out on these matters are needed.

/s/ Lynwood E. Williams, M.D.,
Councilor Second District

THIRD MEDICAL DISTRICT

It is my pleasure to report, as Councilor of the Third Medical District, that harmony and goodwill has been most evident. There has been only one complaint, and it was of a minor nature.

We had two District Meetings during the year. One in the Fall and another in the Spring. They were held at Wilmington, N. C. We had good attendance and the programs were excellent.

Your Councilor has attended each of the Meetings of the Executive Council.

/s/ Dewey H. Bridger, M.D.
Councilor Third District

FOURTH MEDICAL DISTRICT

Your Councilor has attended all meetings of the Executive Council. He has not as yet made the rounds of attending all of the county societies, but will strive to do so in the ensuing year. Efforts have been made by personal visit, telephone calls, and correspondence to (1) encourage State Society membership among physicians in the district who are not enrolled, and (2) resolve differences between physicians coming to the attention of the Councilor. Fortunately, the latter have been few and easily resolved with a single exception which is still pending. Several instances of dissatisfaction among older physicians formerly holding Life Membership who by virtue of the recent Constitutional changes are no longer eligible for this category membership have been brought to my attention and unfortunately this issue is obviously a source of considerable hostility towards the Society from some of its oldest and most treasured members; so much so, in fact, that it is the opinion of this Councilor that the House of Delegates at the forthcoming annual session give some thought to working out a solution acceptable to all.

/s/ Edgar T. Beddingfield, Jr., M.D.
Chairman

FIFTH MEDICAL DISTRICT

The Fifth District members met at Pinehurst, N. C. during November for a full day's Scientific Program which was well attended by doctors and their wives from the district.

The officers for the following year are: Dr. Zack Long, Rockingham, N. C., President and Dr. Charles Phillips, Pinehurst, N. C., as Secretary and Treasurer.

Plans are now in progress for our 1960 meeting which will be held at Mid Pines in Pinehurst, N. C. in November.

I am happy that a healthy atmosphere prevails throughout the fifth Medical District at this writing.

As Councilor I have attended all Executive Council meetings as well as the County Officers Work Shop.

All requests from the Central Office concerning legislation have been complied with.

/s/ Ralph B. Garrison, M.D.
Councilor Fifth District

SIXTH MEDICAL DISTRICT

The annual meeting of the Sixth District was held in the Chapel of the North Carolina State Hospital, Raleigh, North Carolina on November 11, 1959. The program was provided by Dr. Walter A. Sikes, Superintendent, and members of his staff, and papers were given on hospital treatment; progress in the use of drugs and psychiatric care.

The outgoing officers are:

Joseph Combs, M.D., Raleigh North Carolina—
President.

A. G. Crumpler, M.D., Fuquay Springs, North
Carolina—Vice-President.

James Manly, M.D., Raleigh, North Carolina—Secretary-Treasurer.

The officers elected for the current year were: Joseph D. Mayo, Jr., Henderson, North Carolina—President.

John T. Lloyd, M.D., Louisburg, North Carolina—Vice-President.

Malone Parham, M.D., Henderson, North Carolina—Secretary-Treasurer.

The Councilor, in conjunction with the Executive Secretary and other officers of the Medical Society, has made an effort to gain the membership of those men who are not now members in order that we might meet the numerical status to qualify for an additional representative to the House of Delegates of the American Medical Association. This district has an unusually large number of physicians who are not now members. Appeals have been made to them directly and through the officers of their local Societies.

The Councilor has attended each of the meetings of the Executive Council, and has also attended some of the meetings of the counties in this district. The Councilor, on behalf of the District he represents, welcomes into its membership, the Chatham County Contingent.

There have been no unusual problems, and no grievances which have not been amicably settled. There was a single case in which it was apparent that one of our members possibly violated a provision of our established code of ethics by circulating a printed memorandum. It is the information of this Councilor that this physician has removed himself from this district.

/s/George W. Paschal, Jr., M.D.
Councilor, Sixth District

SEVENTH DISTRICT MEDICAL SOCIETY

The Seventh District Medical Society had its annual meeting on Wednesday, October 21, 1959 at Troy, N. C. and an excellent program was arranged by its officers composed of Dr. Fred T. Craven, President, of Concord, Dr. Vernon L. Andrews, Vice President, of Mt. Gilead, Dr. Charles Highsmith, Secretary-Treasurer, of Troy, and the entire membership of the Montgomery County Medical Society and its Auxiliary.

The Montgomery County Medical Society of which Troy is the County seat has only about eight doctors and they all worked hard in arranging a program and also a fine program for the Seventh District Woman's Auxiliary of which Mrs. Phil Barringer of Monroe is the District Chairman.

An excellent program was put on by physicians from the three State Medical Schools. Dr. Frank R. Johnston of Bowman Gray School of Medicine discussed "Peripheral Arterial Emboli." Dr. Dan Young, University of North Carolina School of Medicine spoke on "Newer Agents In The Treatment of Congestive Heart Failure." Dr. John Verner, Jr., Duke University spoke on "Nutrition—Stress—and Vascular Disease."

Following this a banquet was held at the Mont-

gomery Country Club. At the banquet meeting short talks were made by Dr. T. E. Lassiter, Dr. Fred Craven, Dr. John C. Reece—President State Medical Society, Mr. James T. Barnes, Executive Director of State Medical Society. This was climaxed by an address by Mr. Horace Cotton of Southern Pines on the subject "Ten Years of Socialized Medicine in Great Britain."

The ladies had an excellent program on the afternoon of October 21, 1959, and the ladies of Montgomery County are to be congratulated upon their fine work.

The new officers of the Seventh District Medical Society are as follows:

President Dr. Vernon L. Andrews, Mt. Gilead
Vice-President Dr. Leslie Morris, Gastonia
Secretary-Treasurer Dr. Jesse Caldwell, Gastonia

The next meeting of the Seventh District Medical Society will be held in Gastonia in October 1960. We are looking forward to a great time in the thriving community of Gastonia.

One of the highlights of the year was a meeting of the Seventh District's Committee on Rural Health and Education held at Pfeiffer College, very near Albemarle. Dr. William F. Eckbert is Chairman of the Committee on Rural Health of the Seventh District and an excellent program was arranged. Dr. Eckbert is to be congratulated on arranging such a fine program.

Reports were made at the Community Health Conference by Dr. David Harris of Montgomery County, Frances Setzer of Cabarrus County, Anne Blainey of Anson County, Mrs. Hudson of Union County, and a special report by Mr. Harold Furr of Stanly County about the new Locust Medical Center. The regular report of Stanly County was by Mrs. Brooks.

Following this there was a panel discussion on "Occupational and Industrial Health Programs". Dr. William F. Eckbert was the Moderator and the panel consisted of Dr. R. S. Stephens, Cannon Mills, Kannapolis, Dr. George E. Eddins of Albemarle, Mr. James Althaus, Provident Life Insurance Company, Gastonia, and also Mr. Dave Mauney, Personnel Representative of Alcoa, Badin, N. C.

This was a very worth-while panel discussion and was enjoyed by everyone.

The following County Rural Health Chairmen were present at this conference.

Cabarrus	Dr. A. L. Barringer
Union	Dr. J. P. U. McLeod
Stanly	Dr. T. F. Kelly
Mecklenburg	Dr. Ralph Reid

These Area Community Health Conferences are extremely important and worthwhile. This conference was attended by 100 interested individuals.

Annette S. Boutwell, Rural Health Consultant, was present and her counsel and advice was well received.

Pfeiffer College made this meeting very enjoyable.

These Area Community Health Conferences are of great value as attested to by the fine attendance at this meeting and the interest shown in it. More such meetings should be held.

/s/ Claude B. Squires, M.D.
Councilor

EIGHTH MEDICAL DISTRICT

The Eighth District had a normal routine year for 1959. The Councilor was not called on to make any special investigations. However, he did visit with most of the member County Societies and attended an excellent annual meeting in Leaksville-Spray in the fall.

The next annual meeting is to be held in Mt. Airy.

/s/ M. D. Bonner, M.D.
Councilor, Eighth District

NINTH MEDICAL DISTRICT

The past year in the Ninth Medical District was marked by complete harmony. The annual meeting was held Thursday, September 24, 1959 in Hickory. The medical program and social functions were outstanding. Officers for 1960 are:

President	Dr. G. M. Billings
Vice-President	Dr. J. B. Helms
Secretary-Treasurer	Dr. L. B. Snow

The Ninth District meeting this year will be held in Morganton.

/s/ Thomas L. Murphy, M.D.
Councilor

TENTH MEDICAL DISTRICT

During the past year, the overall set up in this District has been fine. I know of no friction or disagreements in our ranks, and all of our County Societies are having regular meetings, and during January and February 1960, in company with my alternate Councilor we have visited all of our County Societies, and found everything in Apple Pie order.

/s/ W. A. Sams, M.D.
Councilor

REPORT OF HOSPITAL SAVING ASSOCIATION

The comparative figures for calendar years 1958 and 1959 listed below show that Hospital Saving Association made significant gains in every phase of operation. The Physician Trustees elected to the Board of Directors of Hospital Saving Association—Dr. V. K. Hart, Dr. Karl B. Pace, Dr. John S. Rhodes, and myself—have attempted to faithfully represent the Medical Society of the State of North Carolina and have regularly attended Board meetings, Executive Committee meetings, and carried out applicable duties on Committees of the Board of Trustees. We have found Mr. Crawford and the staff of Hospital Saving Association cooperative, efficient, and ever mindful of the traditions, ethics, and problems of the private practice of medicine.

These are the figures:	1958	1959
Assets	\$6,147,461	\$6,981,762
Legal and Operating Reserve	3,024,183	3,485,470
Administrative & Sales Expense	9.5%	9.1%
Surgical & Medical Participants	514,366	542,272
Doctor Payments (Surg. & Med.)	\$2,627,360	\$2,948,822
Number Claims	95,087	100,955
Hospital Participants	535,306	562,167
Hospital Payments	\$9,070,628	\$10,183,083
Number Admissions	85,432	88,833
Number Hospital Days	515,800	542,767
Hospital Adm. Per 1,000 Members	161	162
National Blue Cross Adm. Rate	140	140

In addition to Blue Cross and Blue Shield payments, the Association handled 11,905 Medicare claims for physicians and paid \$1,057,000 to doctors under the Medicare Program administered for the Medical Society.

These were the highlights of 1959 operations, particularly as they pertain to interests of the medical profession:

SENIOR CERTIFICATES—Following favorable action by the House of Delegates in May, 1959, at the Asheville meeting, the Association implemented for the State Medical Society a Senior Certificate Program offering initial enrollment to persons 65 years of age and over. This was established as a complete Program providing hospitalization, surgery, medical and radiation benefits at a cost of \$6 per month per individual. The Association has supported this Program with much enrollment and advertising effort. The Association and its Physician Trustees believe that the Medical Society acted with foresight in establishing this Service Program for low-income older persons at reduced scheduled allowances. If Blue Shield does as well in other states, the pressure for Forand type legislation should be considerably reduced.

ORAL SURGICAL RIDER—For some years past, dentists in North Carolina have expressed dissatisfaction with their status as regards eligibility to receive payment for certain procedures. At a joint meeting attended by representatives of the Dental Society, the North Carolina Insurance Department, and the Association, it was determined that present coverage provides only for the services of licensed physicians. However, it was also determined that the Enabling Act was permissive if the Association developed separate coverage for oral surgery. The Association took the position that it was necessary that physicians and dentists come to a prior meeting of minds as to which procedures were rightfully classified as

dental surgery. Dr. Jacob H. Shuford, Chairman, and the other members of the Medical Society Blue Shield Committee are to be commended for the amount of time and effort they devoted to achieve a mutually agreeable schedule for dental procedures. Following several joint meetings of the Blue Shield Committee and the Insurance Committee of the North Carolina Dental Society, a schedule of allowances was agreed upon, and an Oral Surgical Endorsement providing benefits to dentists for certain oral operative procedures will soon be offered to the public.

UTILIZATION OF HOSPITAL FACILITIES AND ADDITIONAL BENEFITS FOR OUTPATIENT SERVICES—As I have stressed in the past several Annual Reports, increased costs of hospital services and increased utilization are critical matters, because there is the danger that adequate hospital coverage may be placed out of the reach of so many marginal income people that some sort of Federal program will become inevitable. In the fall of 1959, the Association sent a letter to every hospital administrator and every chief of staff calling to their attention these dangers and seeking cooperation in ways by which costs might be reduced. This related not only to the admission of persons who could be treated on an outpatient basis, but also administrative practices, such as operating room schedules, advance notice to the family as to the discharge hour, stop orders on medications, etc. The response in some areas was gratifying, and negative in other areas.

Many physicians believe that this problem could be eased by a mandatory deductible and/or the addition of outpatient benefits.

A deductible provision would be a logical and desirable approach if it were made mandatory by State Law and affected all health insurers equally. The Association has offered for several years a choice of a \$25 or \$50 deductible hospital coverage and public response to this has been minimal. The reasons for this seem to be that the public has considerable medical expense, such as dental work, eyeglasses, examinations and immunizations in physician's office, medicines, etc., which are generally not covered under insurance programs. Labor in general considers a deductible as a deterrent to prompt and necessary care and a transfer of expense from the tax-exempt premium contribution of industry to the pocketbook of the worker.

On the matter of providing additional benefits for outpatient services, the outlook is brighter. The Association has recently revised and liberalized benefits under its "Extended Benefits" Endorsement. While it is not possible to provide these extra benefits under the basic hospital surgical and medical contracts, for an additional group rate of only \$1 per individual and \$2 per family, the Extended Benefits coverage adds many outpatient benefits. Without requirement for hospitalization, benefits include outpatient x-

rays and laboratory tests at 80% and radiation therapy at 80%. Following hospitalization, benefits are provided for physicians' home or office treatment, private duty home nursing, and visiting nursing services. This coverage also extends and liberalizes benefits of the basic coverage for prolonged hospitalization. Additional benefits under this Endorsement of special interest to physicians are allowances for facilities and materials used in doctor's offices in connection with care of injuries or major surgery. Thus, the physician will be entitled to be reimbursed for cast material, sterile supplies, medications, etc., in addition to any applicable allowance under the surgical schedule for treatment of fractures, wounds, etc. These additional benefits for care in physicians' offices may offset any incentive that patients or physicians may have had for treating such cases in hospital.

The Association already has over 60,000 persons covered under Extended Benefits, and we expect a rapid increase in sales during 1960 and thereafter. These changes in the Extended Benefits Endorsement were effective March 1, 1960, and coverage was made available to non-group, as well as group, subscribers.

The Association continued its special efforts to make coverage available to all citizens of the state, particularly in rural areas through non-group enrollment for those not employed in groups of five or more and through associated groups, such as the North Carolina Farm Bureau and the North Carolina Grange. There are now over 27,000 people protected in these two special farm groups alone.

The Association has maintained close liaison with the President of the Medical Society, President-Elect, and Executive Director. The President-Elect has regularly attended Board meetings and his discussions and help have been most valuable. I understand that the Professional Relations Subcommittee of the Medical Society Blue Shield Committee is making every effort to increase liaison and understanding with individual physicians and County Medical Societies.

I believe that Blue Shield operations in North Carolina rest on a firm basis of public service and the best traditions of medicine. On behalf of the Association, I take this opportunity to thank all the physicians who assisted and supported the Association on an official Medical Society basis and as individual practicing physicians.

/s/ E. McG. Hedgpeth, M.D., Medical
Director, Hospital Saving
Association

REPORT FROM THE HOSPITAL CARE ASSOCIATION TO THE HOUSE OF DELEGATES OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

The four physicians elected by the State Medical Society to the Board of Directors of the Hospital Care Association regularly attended meetings of the Board at the home office of the As-

sociation in Durham on the fourth Tuesday of each month. At least three physician Directors were present at each meeting.

We are pleased to report that 1959 was another year of outstanding progress for the Hospital Care Association. In every area of its business the Association moved forward.

Enrollment

As of December 31, 1959, the total enrollment in the Association was 342,809 members, representing an increase of 18,821 new members over the previous year. This gain of 5.8 per cent was the most new members Hospital Care has enrolled in any year since 1956. Some 250 new business, industrial, and organizational groups enrolled in the Association during the year.

Significantly, 332,879 of all Hospital Care members have both hospitalization and surgical benefits. Many also have in-hospital medical benefits, Extended Benefits, Major Medical, or Dread Disease Endorsements.

Benefit Payments

Payments to physicians and hospitals during the year amounted to \$8,144,001.42. This represents an increase of 13.8 per cent over 1958 payments.

The total amount paid by the Hospital Care Association to hospitals and physicians since it was chartered in 1933 now approaches \$60,000,000.

One out of every three families with Hospital Care had a hospital or surgical bill paid in 1959. In-patient hospital and surgical admissions totaled 126,160—an average of 2,426 claims processed and paid weekly. Members received 337,590 days of care in hospitals, plus out-patient accident and surgical benefits.

Increased enrollment, higher hospital costs, and increased utilization of benefits were responsible for the record benefits paid by the Association during the year. As hospital charges continued to increase, Hospital Care benefits were increased accordingly.

The Association's executive vice president, Mr. E. M. Herndon, in his annual report to the Board of Directors, noted that more enthusiastic support was received from hospitals and doctors than ever before. He expressed the feeling that this reflects increasing recognition by doctors and hospitals that prepayment is becoming more and more essential to their patients.

Range of Services

The Association has constantly increased its schedules of benefits and broadened its scope of services until at the present it offers:

- A Comprehensive certificate on a bed and board allowance up to \$20 a day, with certificates providing either 70 or 120 days of care per confinement.
- Five surgical schedules ranging up to a \$300 maximum (97 percent of all members have both hospital and surgical benefits.)
- Hospital-medical program of benefits which

includes a wide range of in-hospital medical payments.

- Endorsements to basic certificates include guarantee of semi-private accommodations, out-patient x-ray and laboratory, extended benefits and major medical (\$10,000 maximum) and dread diseases (\$7,500 maximum).

Senior Citizen Plan

During 1959 Hospital Care Association introduced a new Senior Citizen certificate exclusively for persons over 65 years of age. This plan gave North Carolinians 65 and over and in reasonably good health their first opportunity to obtain Blue Cross protection on a nongroup basis. More than 600 persons had enrolled on the Senior Plan when this report was prepared, and additional hundreds of applications were being processed.

Financial Condition

The financial condition of the Association as of December 31, 1959, was as follows:

Assets	\$5,583,840.25
Liabilities	2,636,261.73
Reserve	2,947,578.52

The reserve fund is adequate to meet the financial requirements of the national Blue Cross Commission and the North Carolina Department of Insurance. At the present level of operating expenses, the Reserve would sustain the Association for approximately four months.

Rural Program Expanded

With the cooperation of the North Carolina Farm Bureau in the Eastern and Piedmont sections of the State, and the Farmers Federation Cooperative in Western North Carolina, the rural enrollment program inaugurated by Hospital Care in 1953 was extended into additional counties. Over half the counties in the state now have Blue Cross groups with the Association.

A mobile enrollment office visited the smaller, rural communities of the state offering local citizens not affiliated with organized rural groups an opportunity to join Blue Cross on an individual family plan. Forty-four communities in 25 different counties were visited by this mobile enrollment office.

New Blue Cross Building

To provide for more administrative work space needed to take care of its expanding enrollment and anticipated future growth, the Association purchased on December 23, 1959, property for the construction of a new home office building.

The property, comprising approximately 5½ acres, is located in a residential area at the intersection of South Duke Street and Morehead Avenue, a few blocks from downtown Durham. A new two-story home office building will be built on the site beginning early in 1961. The building will have around 30,000 square feet of floor space compared with around 17,500 square feet which the Association has in its present building on West Geer Street.

National Growth

The Blue Cross program continued to grow

nationally. The 83 approved Blue Cross Plans in the United States and Canada ended 1959 with a combined enrollment of nearly 56 million for a net gain of over 450,000 new members for the year. The total national Blue Cross hospital and medical care payment was well in excess of 1½ billion dollars.

Blue Shield Approval

In May 1958 the House of Delegates of the Medical Society voted to approve the Hospital Care Association as a Blue Shield Plan on the same terms and basis with the Hospital Saving Association. The Association was subsequently advised by the Medical Society that in order to be granted Blue Shield approval the four public representatives on its Board must be elected by the eight other members of the Board, which include four hospital representatives and four physicians elected by the Medical Society.

The Board of Directors of the Hospital Care Association at first declined to make this change in its Board structure. However, the Board reconsidered its position in December 1959 and voted to make the change in its method of electing public representatives as requested by the Medical Society.

The Executive Committee in January 1960 fully approved Hospital Care Association as a Blue Shield Plan and administrator for the Doctors Program in North Carolina, on exactly the same terms and conditions as the Hospital Saving Association of Chapel Hill.

Following this action by the Executive Committee, Hospital Care Association made formal application to the Blue Shield Medical Care Plans, Chicago, for full approval as a Blue Shield Plan. The Association's application is expected to receive favorable consideration at the annual meeting of Blue Shield Plans in California in April.

We are convinced that the Hospital Care Association is endeavoring to provide the people of our state with what they want, need, and can afford in health service protection. The Association is continuing to work toward expansion of benefits and it is ever seeking ways and means to get these benefits to the uncovered segments of our population—the unemployed, the aged, and the medically indigent.

We have enjoyed attending the monthly meet-

ings of the Board of Directors in Durham during the past year. We have carefully studied the operating procedures of the Association and we feel the Plan is well directed by its Board and well operated by its executive staff.

We feel that Hospital Care Association is making a substantial contribution toward our mutual objective of providing the people of North Carolina with a superior health care program. It is a service organization worthy of the high regard in which it is held throughout the state.

/s/ J. Street Brewer, M.D.
Chairman

REPORT OF THE ACTIVITIES OF THE NORTH CAROLINA MEDICAL CARE COMMISSION FOR THE YEAR ENDED DECEMBER 31, 1959

Submitted by physician members representing the Medical Society on the North Carolina Medical Care Commission.

Construction of Hospitals and Medical Facilities

At the end of the calendar year, the Commission had approved contributions involving Federal and State funds in a total of 318 projects to provide improved medical facilities throughout the State at a cost of \$151 million. The Federal share of the costs represents 42.4 per cent; the State share, 12.0 per cent; and the local share supplied by the project sponsors, 45.6 per cent. These projects by medical type are listed as follows:

General Hospitals	157 (8,034 beds)
T. B. Hospitals	2 (100 beds)
Mental Hospitals	7 (647 beds)
Chronic Disease	5 (351 beds)
Facilities	
Rehabilitation Facilities	5 (130 beds)
Outpatient Departments	12
Health Centers	84
Nurses' Residences	46 (2,592 beds)

Of the above, 258 have been completed; 35 are under construction; and 25 are in the planning state. The Commission is currently responsible for 60 active projects involving a total cost of \$55 million.

The gratifying progress not only in providing additional medical facilities but in improving the safety of hospital physical plants throughout the State is reflected in the following comparative figures:

	1947		1959				Increase or Decrease	
Total Existing	Hospitals	Beds	Hospitals	Beds				
Acceptable	122	9,011	161 (10)	17,108 (694)			+ 8,097	(694)
Replaceable	30	3,823	114 (7)	13,963 (545)			+10,140	(545)
Per Cent Acceptable	96	5,188	54 (3)	3,145 (149)			- 2,043	
Per Cent Replaceable		42.4		81.6%				
Total beds per thousand		57.6		18.4%				
Acceptable beds per thousand		2.5		3.8				
Replaceable beds per thousand		1.1		3.1				
Percent increase number hospitals		1.4		.7				32%
Per cent increase total beds								90%
Per cent increase acceptable beds								265%
Per cent decrease replaceable beds								39%

Because of the increasing population, acceleration of utilization of hospitals and the continuing depreciation of existing physical plants, the Commission is receiving more applications for grants under the construction program than during any previous period of its history. While the State has about 17,000 general hospital beds either completed or under construction, it is estimated that an additional 3,000 beds are now needed to keep pace with the current population and 3,000 existing beds require replacement in the interest of adequacy and public safety.

North Carolina continues to rank first in the total number of projects approved under the Hill-Burton Act, fourth in the number of beds, second in the number of health centers and about ninth in the total funds expended.

Programs for Licensing Hospitals and Nursing Homes

During the past year, the licensing program for hospitals has become more active and through many inspections, a number of deficiencies have been revealed in existing plants. It has been regarding to note the cooperation of hospital owners in undertaking improvements recommended. During the year, 166 hospitals were licensed by the Commission, including 15,831 beds.

One program of significance which was inaugurated during the past two years is that of testing operating and delivery room floors and equipment to determine compliance with safety standards. Special equipment was procured for this service. More than half of the hospital floors examined were found to be deficient in providing maximum of safety where flammable anesthetics are employed. These facilities are now being corrected in accordance with the latest requirements of the National Fire Protection Association.

The Commission has proceeded cautiously to assure the accreditation only of nursing homes

operated in buildings reasonably well designed for nursing services and operated by a qualified staff. It has been gratifying to observe the gradual replacement of existing inadequate plants by modern and efficient buildings. There are now 30 facilities licensed as nursing homes under the Commission's program, providing about 1,000 beds. An additional number of modern facilities are now in planning. Of the 30 nursing homes licensed, 70 per cent employ registered graduate nurses.

Hospitalization of the Medically Indigent

This program provides contributions to hospitals of \$1.50 per day for each medically indigent patient certified by the welfare departments. Based on the fiscal year ended June 30, 1959, there were a total of 19,282 claims paid under this program, representing a total of \$295,551. For this period, claims were paid for a total of 197,034 days of care. The average payment per claim was \$15.32, which represented an average length of stay of 10.2 days per patient discharged. A total of 138 hospitals received payments under this program.

For the 1955-1957 biennium, the average length of stay per claim was 11.1 days. For the 1957-1959 biennium, the average length of stay was 10.7 days. For the first six months of the year beginning July 1, 1959, the average length of stay was 9.6 days.

Student Loan Programs

The Commission's programs for providing loans to worthy students of medicine, dentistry, pharmacy, nursing, psychology and sociology who will agree to practice either in small rural communities of the State or in one of the State-owned mental hospitals for designated periods was accelerated during the past year. The results of these programs for recent years are summarized below:

	1955-1957	1957-1959	1945-1959
New Applications Approved	34	50	174
Rural Practice Program	30	46	157
Medicine	13	27	88
Dentistry	8	11	34
Pharmacy	2	4	15
Nursing	7	4	20 ^{1/2}
State Hospitals Practice Program	4	4	17
Medicine	4	3	16
Nursing	0	0	0
Psychology	0	0	0
Social Work	0	1	1
Loan Recipients in Practice	20	45	45
Rural Practice	20	42	42
Medicine	18	28	28
Dentistry	2	10	10
Pharmacy	0	3	3
Nursing	0	1	1
State Hospitals Practice	0	3	3
Medicine	0	2	2
Social Work	0	1	1

1/ 11 in Hospital Schools of Nursing (Diploma course)

9 in Collegiate Schools of Nursing (Degree Course)

From 1945 to June 30, 1959, defaults in completing services in accordance with the conditions of the loans approved represented about 5.7 per cent of the total applications accepted. It is expected that, if the State continues to make appropriations for this purpose, within a few years the rural loan program may become self-perpetuating. This could be possible inasmuch as the rural loans are repaid with interest, thus enabling the financing of additional loans from repayments by recipients previously approved.

J. Street Brewer, M.D.

Powell G. Fox, M.D.

Harry L. Johnson, M.D.

ADMINISTRATION COMMISSION

Wayne J. Benton, M.D., Chairman

Parkinson's Law: "The Deliberations of any Finance Committee will be in inverse proportion to the sum involved."

The Financial Report ending December 31, 1959 shows a healthy surplus of income over expenditures. Sixty-seven per cent of this surplus was due to the activities of headquarters office in selling national and local advertisement. The biggest item in the budget still remains the Journal, accounting for 33% of the total budget. Headquarters activities was next with 24% of the total. All the remaining departments range from 6% to 11%.

You will note that the total expense of the Journal was \$60,308, while the income from advertisement amounts to \$60,973 or a profit of \$665.00. This is somewhat misleading in that the headquarters office does most of the selling of the advertisement, and the expense to this office is not shown in the Journal budget.

You can also see that the expense of the annual convention is met by the income from the exhibits and sale of banquet tickets. But here again the effort of our headquarters personnel is not shown in these figures.

The Finance Committee in cooperation with the Publications Committee and Headquarters Office is making every effort to make the Journal and annual convention self-supporting, and I believe it will be done.

All surplus funds have now been invested in an open end Mutual Fund of stocks and bonds, and a better return on investments is expected in the future. Prior to 1959 our surpluses were invested in government bonds.

Our real estate investment on the Raleigh Durham Highway continues to be good, and it can be liquidated any time need should arise at a profit.

Headquarters Office continues to be run efficiently and effectively. There was no apparent friction or dissatisfaction among the personnel.

So, all in all, 1959 looks rosy, and may 1960 do as well.

The committee is glad to report that through Mr. Barnes' effort and cooperation with the committee, additional facilities were secured for the Medical Society Headquarters on the second floor of the Capital Club Building in Raleigh. These facilities are adequate to meet our needs for an indefinite time.

It is recommended that the functions of the Committee on Medical Society Headquarters Facilities be delegated to the Finance Committee. This is because the question of building the Headquarters building will be dormant for the time being, and the Finance Committee can adequately handle other problems during the interim.

/s/ Wayne J. Benton, M.D.
Chairman

ADVISORY AND STUDY COMMISSION

Jacob H. Shuford, M.D., Chairman, reporting.

1. Committee Advisory to Auxiliary and Archives of Medical Society History—Roscoe D. McMillan, M.D., Chairman
 - a. There were two meetings of this Committee. Considerable time and effort devoted to Legislation, AMEF, student loans, and mental health problems.
 - b. Auxiliary plans to set up mental health endowment similar to tuberculosis bed endowment. Objectives to be training of medical and allied personnel, research, and improvement of patient care.
 - c. The Chairman suggests the Auxiliary rewrite its constitution and by-laws, and increase dues from one dollar to two dollars.
- Archives of Medical Society History: Various subcommittees appointed to compile historical records concerning varied aspects of medical history including past Boards, special committees, and specialties.
2. Committee on American Medical Education Foundation—(AMEF)

Ralph B. Garrison, M.D., Chairman

 - a. Direct gifts to medical schools\$60,000.00 (1958)
 Gifts thru AMEF 4,255.00 (1958)
 Gifts to date to AMEF 6,000.00 (1959)
 - b. The three medical schools will receive from AMEF \$22,000.00 plus direct gifts and earmarked funds. Each school will receive more than our total contribution to AMEF. North Carolina ranks 33rd in amount of gifts through AMEF.
 - c. The Committee calls attention to the fact that gifts can be made thru AMEF and earmarked for school of choice without affecting total amount that the school would receive from AMEF otherwise. It is the opinion of the Chairman that an increase in Medical Society dues may be the only answer in improving our support of AMEF.

RECOMMENDATION: The consideration of raising Medical Society dues, earmarked for AMEF, be given by the proper authorities.

3. Committee on Blue Shield

Jacob H. Shuford, M.D., Chairman

a. Approximately 52% of North Carolina physicians now participate in the Doctors Program. This figure has remained static for three years, efforts being made to develop a fee schedule to cover the first two days of hospitalization as pertains to strictly medical cases.

b. The Committee voted to allow Hospital Saving Association to release lists of participating physicians to interested parties, feeling that such information would aid in the sale of the Doctors program.

c. Approximately 125,000 persons are now covered under the Doctors program.

d. The Senior Certificate is now on sale. Approximately 800 persons have availed themselves of this coverage.

e. Dental Rider has been developed and is now available to the public.

f. Efforts to control needless hospitalization by letters to doctors and hospitals calling attention to local responsibility. Extended benefits endorsement available with liberal outpatient benefits.

g. County Consultants on Blue Shield to be appointed to replace District Subcommittees in an effort to bring the Doctors Program to the local level.

h. Hospital Care Association of Durham, North Carolina, was approved by the Executive Council as qualified to sell and administer the Doctors Program. Hospital Care has made application for recognition to National Blue Shield Plans.

RECOMMENDATION: Continuing efforts to further Doctors Program.

4. Committee on Constitution and By-Laws

Roseoe D. McMillan, M.D., Chairman

Dr. McMillan to report

5. Committee on Medical Credit Bureaus

W. Howard Wilson, M.D., Chairman

a. The Committee is not an approval body—it acts as a source of information to interested physicians.

b. Brochure available to all physicians. Brochure explains advantages, disadvantages, and proper requirements concerning collection agencies.

c. 1959 Exhibit to be displayed again in 1960 at the Annual Meeting. Arrangements are being made to display the exhibit at some future meeting of the A.M.A.

6. Committee to Work with Industrial Commission of North Carolina

Thomas B. Dameron, Jr., M.D., Chairman

a. Base fee for office calls after second visit

increased from \$2.50 to \$3.00.

b. Rating Guide for spine and extremities approved by Industrial Commission. The Medical Society will publish this guide.

c. Industrial Commission Act Amendment to change relative values of various portions of the extremities, to be presented to 1961 General Assembly.

d. Procedures on billing in industrial cases involving third tortfeasor action, circulated to the Medical Society.

e. Work with the Industrial Commission has been pleasant, close and mutually beneficial.

7. Committee on Medical Care of Dependents of Members of Armed Forces (MEDICARE)

David M. Cogdell, M.D., Chairman

a. Effective January 1, 1960, the Medicare Program was restored to essentially the same benefits as originally provided by the Program.

b. Number of claims in 1959—11,905. Amount paid to physicians in 1959—\$1,057,569.00.

c. Bulletins printed and mailed to physicians announcing various changes in the Program.

d. The Medicare Committee has continued to work for a fair and equitable Program to reimburse physicians for civilian medical care provided military dependents.

e. Approximately 25-30 cases per month involving unusual services not covered by the fee schedule have been evaluated by the Committee.

8. Committee on Student AMA Chapters in North Carolina

John P. Davis, M.D., Chairman

a. Student Section Monday evening May 9, 1960, with State Society to sponsor dinner for Senior Medical Students.

b. President John C. Reece to give address of Welcome. An official of the State Society to address the Student Section.

c. Transportation to be provided by the State Society.

d. It is requested that Senior Students be invited to their respective Alumni Dinners.

e. One delegate from each of the three Student AMA Chapters to attend the National Student AMA in Los Angeles, California.

/s/ Jacob H. Shuford, M.D.
Commissioner

ANNUAL CONVENTION COMMISSION

This Commission Report will not repeat details covered in the Annual Reports of its six Committees but will attempt to summarize them.

(1) THE COMMITTEE ON ARRANGEMENT OF FACILITIES FOR THE ANNUAL SESSION, John Rhodes, Chairman, met in August and in September to develop broad plans for the Annual Meeting. Decisions were reached concerning scheduling of the Annual Session in the Coliseum and other facilities on the North Carolina State College Campus, and at the Sir Walter Hotel. The agenda in-

cluded consideration of arrangements for bus transportation between hotels and Coliseum, facilities for the Auxiliary, and location of the President's Banquet at the Student Union and of the President's Ball at the Coliseum. Also considered were arrangements for official guests and for news coverage, and facilities for sectional meetings, alumni luncheons, and golf, skeet shooting, and boating. Because of past difficulties in scheduling the Annual Session, the Committee recommended that selection of the convention city be made routinely three years in advance. This recommendation was made to the Nominating Committee, which is responsible for designating the convention city, and we understand that the following dates and places have been selected and confirmed:

1961—May 6-10—Asheville
 1962—May 5-9 —Raleigh
 1963—May 4-8 —Asheville

- (2) THE COMMITTEE ON CREDENTIALS OF THE DELEGATES, Tilghman Herring, Chairman, certified all delegates to the 1959 Sessions. At a meeting in Pinehurst in September the Committee discussed means of accelerating the checking of credentials and took under consideration the use of a card file system at the Annual Meeting.
- (3) THE COMMITTEE ON AUDIOVISUAL SCIENTIFIC POSTGRADUATE INSTRUCTION, Leonard Goldner, Chairman, has planned for the 1960 Meeting a motion picture program of general and varied interest with discussion of individual films by members of the Committee.
 The Committee is engaged in assembling a list of currently available films which will be kept at the Headquarters Office, will be brought up to date periodically by the Committee, and will be used not only in the audiovisual program of the Society but also by postgraduate meetings, county societies, and interested members throughout the year.
- (4) THE COMMITTEE ON SCIENTIFIC EXHIBITS, Ralph Coonrad, Chairman, has assembled for the 1960 Meeting a total of 36 exhibits. Of 23 exhibits based on individual scientific investigations, 13 are of North Carolina origin.
 The Committee has recommended increased liaison with other program planning committees early in the Society year.
- (5) THE COMMITTEE ON AWARDS AND SCIENTIFIC WORKS, Bruce Blackmon, Chairman, has carried out its usual functions of appraising motion picture presentations, scientific exhibits, and other audiovisual media at the 1959 Meeting, and of evaluating during the year the scientific papers eligible for awards at the 1960 Meeting.
- (6) THE COMMITTEE ON THE MEDICAL

GOLF TOURNAMENT. Charles Styron, Chairman, has arranged for the annual tournament to be played at the Raleigh Country Club on May 9 and 10. The rotating golf trophy, a low gross prize, and low net prizes will be awarded.

In conclusion, the Committees of the Annual Convention Commission, led by very capable Chairmen, have functioned efficiently during the past year. They appear to be faced by no major immediate problems. In several areas a broadening of Committee policies, better methods of implementation, and greater cooperation with related Committees are being explored. These activities were facilitated by discussions and contacts incident to the Committee Conclave held in Pinehurst last September.

/s/ R. Beverly Raney, M.D.
 Chairman

THE PROFESSIONAL SERVICE COMMISSION REPORT

Dr. George W. Paschal, Jr., Commissioner

1. COMMITTEE ON INSURANCES

Joseph W. Hooper, M.D., Chairman

The Committee on Insurances was active during the current year meeting three times. The first meeting was held July 30th in Wilmington, at which time the Professional Liability Program was reviewed, and arrangements were made to meet with our underwriters (The Saint Paul Mercury Indemnity Company). The Committee discussed and considered a life insurance plan for the State Society members. It also heard a proposal from J. L. Crumpton of a plan which was more liberal, and offered broader coverage for the Society, in regards to disability insurance. The Committee recommended approval by the Executive Council of this proposal.

The experience with the group Professional Overhead Program and the Catastrophic Hospitalization Program was reviewed. The program was progressing satisfactorily. The Committee recommended that these receive continued endorsement.

At the meeting in Raleigh on September 15th, members present were: Dr. John Reece, Mr. James T. Barnes, Mr. John Anderson, Mr. Don Clifford of the Saint Paul Mercury Indemnity Company, and Dr. Joseph W. Hooper. The Saint Paul Company recommended, in effect, a 10% rate reduction, across the board, of all types of liability insurance being written by the Saint Paul Company, and endorsed by the Medical Society of the State of North Carolina.

The Committee met again on September 25th in Pinehurst, and recommended to the Executive Council that the Medical Society of

the State of North Carolina not endorse any type of life insurance program.

The membership of the Society was to be acquainted with Mr. Crumpton's Company as regards disability Insurance by literature sent out by Mr. Crumpton's office. It was also agreed that members of the State Medical Society be acquainted with decreased rates offered by the Saint Paul Company by literature mailed out by Saint Paul Company over the signature of the Chairman of the Committee of Insurances.

Since the last meeting of the Committee of Insurance, a further rate reduction has been obtained by the Saint Paul Company, in view of a reduction from the Bureau for the physicians in the state. This information was again passed on to the Medical Society through letters from Saint Paul Company's Home Office.

The Committee wishes to point out that it feels that the Liability Program, endorsed and supported by the Medical Society of the State of North Carolina, and administered by the Saint Paul Mercury Indemnity Company, is the best type of liability insurance offered to the membership at this time. Since its inception in 1956, three rate reductions have been obtained, and there is every expectation that further reductions may be obtained in the future. This possibility will be more likely if we have greater participation and support by our membership.

The Committee also wishes to emphasize to the membership that no claims were settled by the Saint Paul Companies prior to thorough investigation by the Committee on Insurances through specialty type panels set up in the areas involved throughout the state. Also no member of the Medical Society of the State of North Carolina has been denied professional liability insurance without thorough investigation by the Committee on Insurances. Professional Liability Insurance has only been denied with consent of the Committee on Insurances.

II. COMMITTEE ON EYE CARE AND EYE BANK

George T. Noel, M.D., Chairman

The Eye Bank needs and services have been emphasized throughout the year. Efforts have been made to obtain greater interest and participation in the Eye Bank from all members of the Medical Society. All speeches before civic clubs have afforded a good opportunity to pass on this information.

The Eye Care Committee has cooperated with the Committees from specialty societies

in recommending vision screening for school children. A definitive outline of this program should be available at an early date.

Discussions have been held concerning billing procedures for indigent patients, paid for by state and local government agencies. Recommendations were submitted to the Eye Surgeons in the State.

Participation by the Committee in the relative value fee schedule has been effective and the eye sections fees have been decided upon and are to be presented for approval to the House of Delegates.

III. PHYSICIAN'S COMMITTEE ON NURSING

Robert R. Cadmus, M.D., Chairman

The Physician's Committee on Nursing has met three times.

During the year, this Committee lost a faithful and beloved member in the death of Dr. Moir Martin.

The Committee has continued its diligent attention on numerous aspects which affected the medical profession of nursing. They have worked jointly with the North Carolina State Nurses Association, and the North Carolina Hospital Association, as well as independently, on the subject of nursing legislation which was submitted to the 1959 session of the State Legislature. Appropriate approval will be outlined prior to any legislation which might be recommended.

Interest has been expressed in following up the House of Delegates of the American Medical Association concerning the participation of physicians in the "Blueprint Test Committee" which determines the questions to be asked on the licensed nursing examinations. This was discussed with the Executive Council. The Committee recommended to the Executive Council that a member of the State Board of Nurse Registration and Nurse Education report to the Society at the annual meeting of Nurse Licensure and Recruitment, believing that our Society should be kept currently informed as to what we should expect in nurse availability for offices, hospitals, and Public Health Departments.

IV. COMMITTEE ON POSTGRADUATE MEDICAL STUDY

Samuel L. Parker, Jr., M.D., Chairman

The Committee on Postgraduate Medical Study met in Pinehurst on September 26, 1959.

The Chairman announced that eleven North Carolina students won the 1959 National Foundations' Health Scholarships. The scho-

larships were awarded nationally to outstanding young Americans seeking careers in one of five fields— i.e., medicine, nursing, physical therapy, occupational therapy and medical social work. Each scholarship is for \$2,000.00 for a total of four years of college training. There were three in medicine, three in nursing, three in physical therapy and two in social work.

The Committee discussed in detail the many seminars, symposiums and other postgraduate medical meetings that are offered to the profession in the State, and also discussed what ways and means they might employ to encourage physicians of the State to attend these meetings. It was brought out that these courses usually draw the same physicians each time. It was felt that the non-specialty groups are lacking in opportunity for postgraduate information and training. A proposal was made to put on one Pilot Project using a type of television program which would be made available to commercial stations, which would attract the physicians the Committee desires to reach.

The Committee suggested that a schedule of events which would include all medical meetings for a given period of time, be published in one monthly issue of the North Carolina Medical Journal. This, it was felt, would allow the physicians to know in advance the meetings they could attend, and avoid conflicts in schedules. The Committee recommended that the listings in the North Carolina Medical Journal be limited to those offered in the State, since the American Medical Association Journal is national, and the specialty groups know in advance the time of their meetings.

The Committee urged that the members of the Society take advantage of and participate in the postgraduate courses which are available to them.

V. COMMITTEE ON NECROLOGY

Charles H. Pugh, M.D., Chairman

The Committee on Necrology met at Pinehurst on September 25th. During the year it has performed its usual duties in listing all physicians who have died. Appropriate information has been filed with the State Headquarters. Deaths for 1958-59 have been published in the Roster with solemn designation. Listing of the 1959-1960 deaths have been made in the Official Annual Sessions Program.

This Committee recommended that the time for the memorial services be changed from the present time on Sunday evening so that the services may be held during one of the

General Sessions. This recommendation was rejected by the Executive Council.

VI. COMMITTEE ON EMERGENCY MEDICAL AND MILITARY SERVICE

George W. Paschal, Jr., M.D., Chairman

This Committee met in Pinehurst, North Carolina on September 26th. The Committee recommended that the Society bear the cost of sending a single interested physician to the Walter Reed Army Institute of Research, at the Walter Reed Medical Center in Washington, D. C., for courses on Management of Mass Casualties. This was approved by the Society, and Dr. James Davis of Durham was selected as our representative. Dr. John T. Lloyd of Louisburg indicated his willingness to go and bear his own expenses. An opportunity was given the entire membership to attend this course through the media of our Journal and our News Bulletin. Both Dr. Davis and Dr. Lloyd indicated that they received much information, and will report to the Committee, who in turn, will disseminate such information that is pertinent.

Forty-eight (48) counties now have written civil defense survival plans. These include all of the target cities within North Carolina. Additional plans have been formulated for the reception and care areas. We now have twenty-one (21) two hundred (200) bed hospital units stored at strategic points in the State. The Hospital unit demonstrated in Asheville last year was also exhibited in three other cities, but further demonstration of this facility was discontinued because there was no Caretaker available at the time of their display. Members of the committee participated in Operation Alert in 1959, which was in conjunction with a national alert. This simulated attack pointed up many weaknesses in our preparedness.

The Committee wishes to call special attention to the "Fall Out Problem". It is urged that every member of the Society familiarize themselves with the plans for survival which have been formulated by students of the problem so that they will be able to take care of themselves, and advise their patients as to their care. It is pointed out at the present time that the essential pre-requisite for survival and avoiding excessive fall out exposure is *adequate shelter*.

The Committee had no problems concerning military affairs during the year.

/s/ George W. Paschal, Jr., M.D.
Commissioner

PUBLIC RELATIONS COMMISSION

There are six committees in the Commission, and the following is a brief resume of their activities for the past year.

1. *Hospital & Professional Relations and liaison to North Carolina Hospital Association.* This committee has had a very active year and has dealt with the problems which have been presented to it in a very constructive manner. Dr. Theodore H. Mees, the Chairman, has conducted his conferences and meetings with dispatch and has made investigations in areas that were requested. The committee has reviewed the developments on cited problems which have arisen out of the present North Carolina survey of hospitals under the standardization program of the Joint Commission.

One of the specific problems which has been considered are the automatic stop orders on drugs which the Joint Commission feels should be standardized throughout all hospitals. The Committee recommends that stop orders should be considered by the staff of all hospitals. The Committee further is studying the concept of the Joint Commission on accreditation to provide hospitals with the information relative to standardization requirements.

The liaison efforts between the Committee and a similar committee of the Hospital Association has been promoted and has been worked out. This conference is aimed at providing better and clearer understanding between the two associations. The Committee is studying and continuing to study the methods of providing medical services to the needy and promoting this care more extensively at local county level.

Two instances of dissatisfaction between medical staffs and hospital administration were thoroughly investigated and are a matter of record with Executive Director of the Medical Society of the State of North Carolina and are available for inspection.

The question of the Placement Service of the Headquarters Office has been extensively studied, and it is the feeling of the Committee that detailed facts relative to situations available should be made before the Headquarters Office of the State Medical Society should intervene in any way in undertaking to place physicians in desirable areas. It was felt by the Committee that the request for additional physicians should be presented on the local level, and then the Headquarters Office should undertake to implement their requests.

2. *The Committee on Legislation.* 1959 was not a legislative year so far as the State of North Carolina was concerned and the Committee has confined its activities to maintaining its rapport with the legislators at the state level and has placed all the weight of its activity behind the program of the American Medical Association in promoting and opposing Federal legislation which has come before it.

The Committee has also had several conferences with the Hospital Association in an effort to provide more adequate revenue for the hospitals from certified welfare cases.

The Legislative Committee has participated extensively in seeking to have defeated the Forand Bill in the Congress of the United States.

3. *The Committee on Medical Legal Relations.* This Committee has been one of the most successful and one of the most active in the Society. The relationship between the Bar Association and the Medical Society of the State of North Carolina is considered at this time to be at the best level in history. This fact is due in no small measure to the efforts of the Committee on Medical Legal Relations.

During the past year Joint Medical Legal meetings have been held in Forsyth County, Buncombe County, and Johnston County. It is felt that other counties have had meetings with the Bar Association, however, these three are the ones in which the Committee has participated. The Committee has considered means to increase interest at future meetings. It was felt that this should be promoted on an individual and local level with the availability of speakers from both the Medical Society and the Bar Association and should be available to the councilors of the districts for dispersion to the local County Medical Society.

Included in this recommendation is the information that four films are available and can be shown to any County Medical Society which desires to have them. It is thought that these films would be well shown at a joint meeting of the Bar Association and the Medical Society.

The interprofessional code has now become accepted and the Committee has undertaken to have 10,000 copies made and distributed to interested individuals and Societies. The Bar Association has shared in the cost of printing this code.

The Committee further recommends that each County Society maintain a Medical Legal Liaison Committee in order that there might be a sounding board for complaints from Members of either profession.

4. *The Committee on Public Relations.* This Committee, under the able chairmanship of Dr. Edgar Beddingfield, has again had a most successful year.

The budget for the Committee is a matter of record with the Executive Director of the Medical Society and is available for inspection.

The Committee has considered proposed public relations activities for the year 1959 and 1960, and in line with that program conducted on the 30th of January 1960, at the Carolina Hotel in Pinehurst, an excellent conference of newly elected county medical society officers. This conference was well attended. The program was well prepared and there was feeling of great accomplishment at the conclusion of the day. The attendance this year for the second time increased almost 100% over the the first year of implementation.

The Committee approved the idea of the American Medical Association exhibit on nutrition

nonsense, display of what America spends and blood typing services. It further affirmed the distribution of informative literature and supported radio series "Medical Milestones" as information.

The Committee also proposed a press award to be made annually in the amount of \$250.00 to the reporter and a plaque for the paper which the reporter represented for outstanding work in the field of medical journalism. This matter is to be considered between the Chairman of the Public Relations Committee and a similar press committee.

The Committee further considered the idea of producing an indoctrination or information booklet for new licentiates. It was suggested that such a booklet should include procedures for admission to state mental hospitals, tuberculosis hospitals and cancer institute. There should be also included as information material on employment security and income tax withholding as well as adoption procedures. This matter was referred to the Executive Council.

The Committee further felt that the Science Fair Program offered a large opportunity at local and state levels for stimulation of interest in the activities of organized medicine. The Committee voted to continue its \$100.00 annual contribution to North Carolina Academy of Science and to continue inviting an exhibitor from the Biological Science Division of the State High School Science Fair to exhibit their display at the annual session of the Medical Society.

5. *The Committee on Rural Health and General Practitioner Award.* This Committee again, under the active leadership of Dr. Hugh Matthews, has conducted its business in an interesting and effective manner.

The detailed report of the Committee on Rural Health and Education and General Practitioner of the year award is a matter of record with the Executive Director and may be inspected.

The Highlights of the year were community health conferences conducted at North Wilkesboro, Buies Creek, Ahoskie, and Misenheimer. Each of these conferences was sponsored jointly by the Committee on Rural Health and Education, and the local community health groups. These conferences were well attended, and as a general rule were held in a relatively central area, so that representatives from four to six counties might be in attendance.

The Committee recommends that the area conference plans, as approved in 1959, be continued.

Due to the obvious lack of interest in the General Practitioner award, the Committee recommends that each District be circularized in an attempt to have each medical district nominate one physician for the General Practitioner award. In the event there is a continued lack of interest in this award the Committee feels it should be abandoned. However, it further recommended that the project be continued for 1960 and that a

positive stand be taken to either continue or abandon the project.

6. *The Committee for Liaison to the Insurance Industry.* This Committee is one of the youngest of the State Society and under the capable chairmanship of Dr. Frank W. Jones, has had a number of conferences with representatives of the insurance industry. To clarify the position of this Committee, a statement of understanding was presented to the Executive Council and was reviewed and modified by the Committee on Constitution and By-Laws, and that revision was approved by the Executive Council. This statement of understanding is a matter of record with the Executive Director and may be reviewed. There has been excellent rapport between this Committee and a Committee of the North Carolina Insurance Industry with the sanction and help of the Commissioner of Insurance of the State of North Carolina, Mr. Charles Gold. Detailed report of this Committee is available from the Executive Director.

/s/ Hubert M. Poteat, Jr., M.D.
Chairman

PUBLIC SERVICE COMMISSION

DR. JOHN R. KERNODLE, Commissioner

All Committees have held one or more meetings during the reported year. Following the September Committee Conclave, each committee recommended this practice be continued and if possible, held earlier so that the work can be outlined and planned as soon as possible after the annual meeting and appointment of committees to avoid interruption of projects and programs.

As Commissioner, I wish to take this opportunity to express appreciation to all committee chairmen and members for their continued cooperation and support of this phase of the Medical Society's program or work.

To briefly report on major activities and recommendations of each Committee, I submit the following:

COMMITTEE ON ANESTHESIA STUDY: Dr. David A. Davis, Chairman. The Committee is continuing its study and review of all reported deaths which relate to the anesthesia as being a primary cause of death. The study now in its sixth year, has sufficient data for publication and it is recommended that such a report be printed in the North Carolina Medical Journal or otherwise distributed to physicians as Information.

Another concern of this committee is that of the number of trained physician-anesthesiologists being trained in our medical school, only a few remain in the state to practice. One registered complaint from the committee referred to the current policy of Blue Cross insurance paying for the services of a nurse administering the anesthesia but not so for a physician rendering such service.

COMMITTEE ADVISORY TO THE BOARD OF PUBLIC WELFARE: Dr. J. Street Brewer, Chairman. Many positive results can be measur-

ed by the influence of this Committee and its close liaison contact and relationship to the State Board of Public Welfare. Last year, the Committee recommended that the Medical Society support specific legislative proposals made by the Board of Public Welfare, many of which were passed and now enacted, especially those bills pertaining to the increase in "pooled" funds for indigent hospitalization; required licensure of all boarding and nursing homes; and permission to pay out-of-state hospitals from "pooled" funds in our bordering counties. Current study is being given to 1. distribution and payment of *drugs* for welfare recipients in cooperation with the Public Relations Committee of the State Society, North Carolina Pharmaceutical Association; 2. increased financial assistance given to the "medically indigent" for hospitalization; and 3. more thorough screening of applicants requesting welfare certification; e.g., the Harnett County demonstration is an excellent example of the joint efforts at the local level to ascertain a working relationship between the local physicians, welfare board, public health department, and with the State Board of Public Welfare's Medical Staff.

COMMITTEE ON CANCER: Dr. James F. Marshall, Chairman. The Committee on Cancer has continued to work closely with the North Carolina Division of the American Cancer Society in research and educational programs, also with the State Board of Health by encouraging physicians to report diagnosed cancer patients to the Division of Vital Statistics.

Emphasis has been given for a number of years to the importance of "each physician's office" being a "cancer detection center" and stressing this fact to all physicians as part of an educational program.

The Committee has continued to work with the Commission for the Study and Control of Cancer, with members serving on this Commission. The 1959 General Assembly voted to continue the work of the Commission for another two years.

Several special projects are worthy of note which the Committee is supporting and participating in:

1. Papanicolaou smear campaign in cooperation with North Carolina Society of Pathologists.
2. Epidemiological study of the American Cancer Society.
3. Cured Cancer Congress to be held in Raleigh on March 26, 1960, in cooperation with the local, state, and American Cancer Society.

The work of this Committee deserves recognition and credit for its sincere interest and demonstrated cooperation in giving guidance and leadership to all programs pertaining to the prevention, rehabilitation, and prolongation of life of cancer patients.

COMMITTEE ON CHILD HEALTH: Dr. Angus M. McBryde, Chairman. The Committee has continued its study, review, and evaluation of infant deaths. This study is conducted with the

cooperation of the State Board of Health. At present 112 hospitals and clinics having a census of 100 or more deliveries per year are being studied. The Committee hopes to expand its study of neonatal deaths to all physicians not presently covered in the study project. The Committee is considering expanding its efforts to study morbidity as well as mortality instances for a better understanding of common problems and to encourage improved standards and practices in hospitals and clinics and during prenatal medicine supervision.

COMMITTEE ON CHRONIC ILLNESS: Dr. John R. Kernodle, Chairman. The Committee has continued to work towards the overall objectives as set up two years ago; namely,

1. to promulgate the education of the people and physician to the increasing problems of chronic illness and aging and to the need of improving facilities, services, and standards of care for these persons throughout the state.
2. to study and influence the passage of all legislation related to the problems of chronic illness and aging in the North Carolina General Assembly and U. S. Congress.
3. and to study, evaluate, and influence medical programs and progress in the field of aging.

Because of the present impact of proposed national legislation (Forand-type legislation), the committee has given major emphasis to working with the A.M.A., State Legislative Committee, and other agencies and professional organizations in alerting local action in opposition to such proposed national legislation. The Committee has also supported state legislation in 1959 in areas pertaining to the financial assistance for welfare recipients; improved licensure for boarding and nursing homes; encouraged volunteer efforts in recruiting and training personnel (reference made to the Red Cross Nurses-aid program); and through its Joint Committee for the Health Care of the Chronically Ill and Aging, has attempted to coordinate programs, services, and resources of various state agencies, organizations, and other interested groups for the best utilization of existing services and to make practical recommendations as to the needs of these persons and how they can be met more efficiently and economically. Home-care services have been pointed up by numerous surveys and studies as the primary need for both the chronically ill and aging. The Committee has cooperated and encouraged local demonstration projects experimenting in rendering such services with present personnel and agency resources.

County medical societies have been requested to appoint chairmen and committees to work with local community leaders and to give guidance and leadership in study projects and to assist in evaluating needs, opportunities, and in planning a coordinated approach at the county

or community level. It cannot be stressed too much the need for local physician participation in such community activities.

Members of the State Committee and the Joint Committee are serving on seven out of the eight sub-committees appointed to work on the Governor's Conference on Aging, scheduled for July 27, 28, 1960. Again, medical leadership and participation was requested and given. The Committee has made a second survey of physicians and county medical societies as to their evaluation of existing facilities and services available for the care of the chronically ill and aging. This is a repeat of the survey made in 1958. Results are expected to be tabulated and reported in time for the Governor's Conference in July. Another study initiated by the Committee in cooperation with the State Board of Health and the North Carolina Hospital Association is a "Hospital Discharge Study." Selecting four weeks, at three month intervals, discharged patient's records are being tabulated to give: 1. identifying data, race, sex, and age; 2. length of hospital stay; 3. total cost of hospitalization; 4. methods of payment; and 5. primary diagnosis for hospitalization. Again, it is planned to have this study reported in time for the Governor's Conference in July. Members of the Committee have attended and participated in a number of national, regional, and state conferences related to the problems of the chronically ill and aging. North Carolina was one of the state medical societies requested by A.M.A. to testify before the House Ways and Means Committee in July, 1959. The Chairman of the Chronic Illness Committee made the report for the Society. Following this action, county societies, allied professional, business, and civic organizations have prepared and sent Resolutions, letters, and other expressions of opposition to the Forand-type legislation proposed in Congressional Committee last year and again in 1960. An all-out effort is being made in the state in cooperation with the A.M.A., in alerting action groups and key leaders in the state to the inadequacies of such legislation and focusing attention to the individual's, and community's and the state's responsibilities for providing adequate care, including health and medical care, to our chronically ill and aging citizens.

These efforts will be continued at all levels and with physicians being encouraged to take action and leadership throughout the state.

COMMITTEE ON MATERNAL HEALTH: Dr. James F. Donnelly, Chairman. The study of maternal deaths is a continuing project of this committee and has received wide recognition for its accomplishments. The Chairman has been appointed to the A.M.A. Committee on Maternal Health within the past year thus bringing further recognition to the Committee and to the State Society.

Recognizing the increased population rate and the ratio of physicians to births, the Committee

made a study in 1959 giving statistics as to the number of physicians (by specialty) tending and supervising deliveries, and projected the number of births per physician within the next five years. This is a real concern for the committee because with an anticipated increase in births, we must have physicians sufficient to maintain the standards of care that we have achieved over the past ten years.

The Committee points with pride to the increased hospital deliveries, improved prenatal care, and the reduction of maternal and infant deaths in North Carolina.

This Committee realized the need for the Medical Society office having complete data on I.B.M. cards regarding each physician in North Carolina. Work along this line is being carried out with Mr. Barnes and his office. All committees have been advised to review data available and make recommendations for questions pertinent to their activities so that these questions may be included on the I.B.M. card.

COMMITTEE ON MENTAL HEALTH: Dr. Allyn B. Choate, Chairman. A sub-committee was appointed to make investigations on recommendations that the Mental Health Clinics, now operating under the direction of the State Board of Health, be transferred to the North Carolina Board of Hospital Control.

The constant problem of recruiting and keeping trained personnel for these clinics was cited as the major reason for wanting this program changed to the North Carolina Board of Control.

The Committee is aware of the need for more psychiatric training for General Practitioners and requested that such training be given in post-graduate courses. Recommendation referred to the Committee on Post-Graduate Training and to the Academy of General Practice. The Committee keeps in close contact with the North Carolina Board of Hospital Control, the State Board of Health, the medical schools, and private treatment centers for the mentally and emotionally disturbed, and continues to be interested in all programs, facilities, and services available. Emphasis is given to the relationships between private physicians and these facilities.

COMMITTEE ON OCCUPATIONAL HEALTH: Dr. Harry L. Johnson, Chairman. North Carolina is honored in 1960 as having been selected as the conference site for the A.M.A. Congress on Industrial Health. The Congress will meet in Charlotte, North Carolina, October 10-12. The State Committee on Occupational Health and the Mecklenburg Committee will be hosts to the national meeting.

Most of the State Committee's work this year has been centered around the planning of the annual Congress and solicits the attendance and support of physicians across the state. The Theme of the Conference will focus attention to the role of the private practitioner in Small Plant and Industry health and medical care services.

North Carolina continues to expand its industrialization and with it, brings the need for more and more local participation on the part of private physicians.

The State Committee continues its cooperation with the Governor's Council on Occupational Health and in sponsoring seminars at the University of North Carolina on Occupational Health Programs and Services.

COMMITTEE ON POLIO: Dr. Samuel F. Ravenel, Chairman. The Medical Society's Committee on Polio sponsored the Bill through the 1959 General Assembly requiring all entering school children to be properly immunized against polio. North Carolina is the first state to have such a law for mandatory immunization. Medical Societies in West Virginia and Virginia are following in the footsteps of North Carolina in regard to state law for polio immunization. The Committee continues to work with the State Board of Health, National Congress of Parents and Teachers, Junior Women's Clubs, and physicians in planning and supporting operational procedures for implementing the law. A four-dose schedule for immunization is now recommended by the State Board of Health. The Welfare Department has been requested to make poliomyelitis immunization a prerequisite to admission to any day-care nursery in North Carolina.

The Committee is to be congratulated for its untiring efforts and leadership given to the 1959 General Assembly action and should be encouraged to continue its program for additional immunization programs and procedures.

COMMITTEE ON PHYSICAL REHABILITATION: Dr. George Holmes, Chairman. A close liaison relationship exists between this committee of the medical society and the Vocational Rehabilitation Program of the state. Such contact has resulted in improved reporting to and from physicians to Vocational Rehabilitation and in a better understanding of community and state agency resources for the physically handicapped among private practitioners.

COMMITTEE ON SCHOOL HEALTH: Dr. Irma Henderson Smathers, Chairman. The Committee has expanded its activities to all phases of the school-health program and has been recognized as a valuable source of leadership for improved health instruction, health services, and coordinated efforts of the community in programs pertaining to the overall health supervision of school-age children.

Major projects for the year include: 1. Study and evaluation of present health text books. 2. appointment of county medical society chairmen to work with school, public health, P.T.A., and other interested community groups on local school-health activities and programs. 3. Planning and sponsoring a State School-Health Conference in the fall of 1960. 4. Cooperation with High Point College in a school-health workshop in the summer of 1960. 5. continued work with the School-

Health Coordinating Service, State Board of Health, P.T.A. "continuous health supervision" program. 6. Increased emphasis to be given to "health careers" through physician leadership and participation at state and local levels.

The Chairman of the Committee attended the A.M.A. sponsored Schools-Physicians Conference in Highland Park, Illinois, October, 1959; participated in the special school-health workshop at Chapel Hill in September, 1959; sponsored by the Children's Bureau; and served as chairman of the Health Committee for Buncombe County for its study and report for the 1960 White House Conference on Children and Youth.

COMMITTEE ON VETERANS AFFAIRS: Dr. Samuel L. Elfmon, Chairman. North Carolina still remains one of the few states to operate with an "intermediary" in its program of home-care for service connected veterans. The Chairman and members of the Committee have given untiring of their efforts and time in maintaining this program as it gives physicians an opportunity to keep up with the operations of such services and also gives them a voice in its functions. Hospital Saving Association has served as the intermediary, making payments, keeping records, etc., the Committee has negotiated with V.A. for a fee schedule and annual contract for medical services rendered by private physicians. The contract is the same as last year. It has been signed and accepted and will be effective July 1, 1960. It is the recommendation of the chairman that only three or four members be appointed to this committee to enhance the close working relationship with the V.A. and the Hospital Saving Association.

COMMITTEE ON AMERICAN MEDICAL EDUCATION FOUNDATION

The Committee on Medical Education Foundation held one meeting during 1959 at Pinehurst, North Carolina. The material from Foundation headquarters was discussed in detail. It was decided by those present that asking for an increase in the State dues of \$10.00 would not be the wise move to make at that time since it would entail changing the Constitution and By-laws and would require some time to get the machinery in operation.

The fact that North Carolina doctors have been quite liberal with their three Medical Schools giving approximately \$60,000 last year while gifts through A.M.E.F. amounted to only \$4,255. It was the opinion of the committee that our doctors did not understand that they could give to their respective schools through the A.M.E.F. and that such giving would not affect the amount that the Medical School would receive from A.M.E.F. otherwise. With this thought in mind we tried to make the proposition clear to the doctors in the state by clarifying the situation through Dr. Shuford's Blue Cross letter, through the Public Relations Bulletin and by letter and telephone

conversation with the President of the Medical Auxiliary.

The time of this report A.M.E.F. has received approximately \$6,000 from doctors and Auxiliary. The final break down has not been received. This amount is a small increase over the 1958 figure and is quite disappointing.

For the sake of brevity I will give you a few figures that I have to date.

Contributions for 1959—total 182 for \$5,995.84. Of the 48 states we rank 33 or 15th from the bottom.

The leading state was Illinois with \$9,559. Contributions amounting to \$200,471.56. Rhode Island with 34 contributors totalled \$835.00, the smallest contributor. South Carolina with 223 contributors totalled \$68,634.14.

Total contributions for U. S. and possessions 55,399 for a total of \$1,195,824.79.

If distribution to the 80 Medical Schools runs about the same as it did last year our three Medical Schools should receive from A.M.E.F. a total of \$22,000 in addition to the money sent in and earmarked for the respective school.

From these figures each of our schools will receive more than our total contribution to A.M.E.F. and State.

What to do about the A.M.E.F. Program in our state in the future is the big question. It is my humble opinion that an increase in the dues for this very worthy and necessary project would be the best solution. Maybe the A.M.A. will come up with the answer—it is a pressing matter and should receive some special consideration.

/s/ Ralph B. Garrison, M.D.
Chairman, A.M.E.F.

COMMITTEE ON ANESTHESIA STUDY COMMISSION

For orientation to new members, the Chairman explained the purpose and functions of this Committee's study of deaths attributed to anesthesia. The effort started some six years ago and a Committee was formed to study this problem on a confidential basis. The State Board of Health agreed to undertake this study, which is similar to that of the Maternal Welfare Committee, obtaining information from the death certificates and notifying the Chairman. Publicity has been withheld today because of the danger of misinterpretation of the public but the Chairman feels that the data should be made available to physicians through selected channels of communication. The Executive Council has given its approval to have this data published through medical channels—May 1959. Results of the study show that some 35 deaths occur each year and since the "near misses" are not recorded, the extent of the problem is probably greater than the actual number of deaths indicated.

A letter is sent by the Chairman of this Committee on each death recorded with anesthesia given as a cause of death asking the physician in

charge of operation for additional information. This has become quite a load for one person to carry and other committee members offered to assist with personal inquiry to physicians in their respective areas if called upon to do so.

Attention was called to the fact that more deaths were recorded as occurring near the end of an operation rather than at the beginning. Another trend cited by the Chairman from these findings, was that either too much agent was being applied or too little oxygen given the patient.

No further increases in budget funds were requested for this Committee.

The Commissioner discussed the Maternal Welfare Committee's interest in having an I.B.M. Card made up on all physicians giving pertinent information and asked this Committee if it would like to add any questions for its own use. The Committee agreed that it would like to know more about the training and qualifications of physicians giving anesthesia today. Questions from this Committee were requested to be sent to Dr. James F. Donnelly, Director of Maternal and Child Health, State Board of Health, Raleigh, N. C.

Personnel shortages seemed to be a major factor of concern with this Committee. In checking on the number of trained physicians remaining in North Carolina to practice, it was stated that one main drawback was the Insurance payment for services. It was reported that insurance companies would pay a nurse anesthetist, if a hospital employee, the going rate of charge, but would not pay on the same scale if an M.D. anesthetist performed the service. The inequality for payment discouraged M. D. anesthetists staying in the state to practice.

Duke reported training some 14 M.D. and nurse anesthetists this past year; Bowman-Gray 2; and UNC 2. The committee members were not complaining so much as to the number being trained as they were over the fact that North Carolina was losing them in practice and they felt the insurance factor did have a bearing upon this loss.

This problem was referred to the Committee on Blue Shield for consideration and given as information to the Executive Council on Sunday, September 27.

/s/David A. Davis, M.D.
Chairman

COMMITTEE ON ARRANGEMENTS

The Committee on Arrangements for the One Hundred Sixth Annual meeting of the Medical Society of the State of North Carolina, to be held in Raleigh, May 8-11, 1960, met August 23, 1959, at the Sir Walter Hotel with the following present:

M. D. Hill, M.D.
Walter Spaeth, M. D.
John S. Rhodes, M.D.

John C. Reece, M.D., President
 Amos N. Johnson, M.D., President-Elect
 R. Beverly Raney, M.D., Chairman, Commission
 III
 James T. Barnes, Executive Director
 Mrs. LaRue King, Secretary

Broad plans for the Annual Meeting and details incident to the change of meeting place were discussed at length. Through Dr. Carey H. Bostian, Chancellor of North Carolina State College, the committee was assured that the Coliseum and other facilities at State College would be available for Society activities. It was decided that the program for the annual meeting would be centered on the campus at the college, while arrangements for activities of the Auxiliary would be made, in the main, at the Sir Walter Hotel. Scheduled bus transportation between the hotel and the coliseum was planned. It was suggested that the President's Banquet would be held at the Student's Union, to be followed by the President's Ball at the Coliseum.

Adequate facilities for sectional meetings will be available on the campus. Arrangements for Alumni Luncheons will be made with the thought of reducing transportation problems to a minimum.

Those interested in golf, skeet shooting and boating will find these facilities available.

Mrs. Ernest Page, representing the Wake County Auxiliary appeared at the meeting to discuss plans relating to the activities of the Auxiliary. It was agreed that bus transportation should be provided for a function at the Carolina Country Club.

In view of the difficulties which have arisen in scheduling and programming the annual meeting, the committee decided to recommend to the Nominating Committee, responsible for naming the place of meeting, that the selection be made for three years in advance. In accord, the Nominating Committee has firmed the following places and dates:

May 6-10, 1961, Asheville

May 5-9, 1962, Raleigh

May 4-8, 1963, Asheville

It is anticipated that this advanced scheduling will permit more effective planning both for facilities and programs.

A second meeting of the Committee on Arrangements was held at the Carolina Hotel, Pinehurst, during the Medical Society Committee Conclave, September 25, 1959. This meeting was attended by Drs. John C. Reece, M. D. Hill, R. B. Raney and J. S. Rhodes and Mr. James T. Barnes and Miss Esther Wall. Plans previously elaborated were reviewed and progress reported.

There is every indication that the annual meeting for 1960 will show an increased attendance over recent years. The executive staff at the headquarters office is hard at work on the details.

/s/ John S. Rhodes,
 Chairman

COMMITTEE ON SCIENTIFIC AUDIO-VISUAL POSTGRADUATE INSTRUCTION

The Audio-Visual and Postgraduate Instructional Courses were held in the West Ballroom, George Vanderbilt Hotel, on Sunday, May 2 and Monday, May 3 in Asheville, North Carolina. The size of the room, the airconditioning and the facilities were excellent and the attendance was good.

On Sunday there were approximately seventy-five persons attending the Audiovisual Section and on Monday there was a total of eighty during the afternoon section and sixty during the morning section. It is not possible to determine the actual individual registration due to the difficulty in getting the names of the Society members as they enter the room.

For statistical purposes and for adequate records, it would be advisable to have a card method of registration in 1960. Each individual entering the room could sign a card with date and time and this would give an index of the attendance at any particular program, and would also give a record of the overall, as well as individual attendance.

It is suggested that prior to the 1960 planning meeting, the Executive Director of the Medical Society gather up-to-date information on all medical motion pictures available. This means that letters should be written to all drug companies that produce motion pictures, information should be obtained from the American Medical Association, the American Academy of Orthopaedic Surgeons and the Central Agency for Medical Visual Aids, whose home office is in Lawrenceville, Kansas. Requests should be sent to the American College of Physicians, the American College of Pediatricians and all other central offices of Academies, requesting information concerning current and up-to-date motion picture productions. The American Cancer Society, the National Foundation, Cerebral Palsy Foundation—all of these groups have participated in motion picture production. Also, the Veterans Administration has motion pictures covering many aspects of medicine. A Central file should be established in the Executive Office of the State Society with all the pictures available.

Letters should be sent to the medical schools in the State and to various county medical societies asking them to send titles of any motion pictures that individual physicians have produced, so that these can be available for showing.

The Audiovisual Committee can then go through all of these motion pictures and make up a recommended current list that might be of interest to local county societies for their particular use and, from this group, the medical schools and postgraduate courses can draw illustrated material for use from time to time during the year. There is a tremendous amount of illustrated material that is not being utilized by the medical profession and paramedical organizations in the State of North Carolina.

For the 1960 program it is recommended that the material included be varied, that it be of general interest and that the members of the Committee be available for discussion of the topics as they are presented.

The Committee on Scientific Audio-Visual Postgraduate Instruction met in the Small Card Room, Hotel Carolina, Pinehurst, N. C., on September 25, 1959 at 1:00 P.M. A report was distributed on summary of Asheville 1959 Meeting with suggested changes for coming year and 1960 meeting. It was the opinion of the Committee that special Postgraduate Instructional Courses are probably not as desirable as continued Audio Visual.

Time of Audio-Visual Program was moved from 2:30 to 2:00 until 5:00 on Sunday, Monday-9:00 to 12:00 and 2:30 to 5:00. Day and method of presentation will continue the same.

It was decided that in reference to discussants for each visual showing that members of the Committee to be appointed to discuss individual showing—this being the sole activity of members of the Committee. Each member should be expected to discuss what presentation is to his greatest interest. Once the program is set up the individual members of the Committee will be designated discussant of a particular showing on an Audio-Visual program. A list will be sent to each member of Committee to choose topic for discussion. It was recommended that a list of films be kept at Headquarters Office up to date and to be publicized once a year and that a list of all films available would be prepared by the Chairman of the Committee and the Central Office to go to all Officers of the County Medical Societies. This list should also be sent to the Deans of the medical schools. Dr. Goldner is to form letter for Headquarters Office to send out. Letter and list of films to be enclosed with March and April PR Bulletin. October PR Bulletin to announce about Sunday program at 2:00.

1960 Budget is estimated at about \$60.00.

Mr. Wayne White and medical students will still be in charge of projection equipment at meeting. Expenses to be paid for by Medical Society. Dr. Goldner will continue to check films in December and send list to Committee for suggestions and approval.

It was requested that Audio-Visual Sections on Sunday and Monday be held in air conditioned room. The room does not have to be larger than to hold 100 people. It was also requested that these Sections meet in the Hotel Sir Walter.

A system of individual card registration at the program was suggested. The card would ask for name, address, what they do, and evaluation of program. It would be given out at door and should be handed in after meeting.

/s/ J. Leonard Goldner, M.D.
Chairman

COMMITTEE ON SCIENTIFIC WORKS AND AWARDS

The Committee on Scientific Awards exercised its usual function at the State Society Meeting in Asheville in May, 1959, which consisted of viewing and judging motion picture presentations, scientific exhibits, and other audio-visual media. The membership of the Committee was well represented, and all members present cooperated in the work to be done.

Since then the name of this Committee has been changed to that of Committee on Scientific Works and Awards. There are no additional activities to be reported other than the usual one of appraising manuscripts, which were presented at last year's meeting. This appraisal is still in progress and on schedule.

/s/ Bruce B. Blackmon, M.D.
Chairman

REPORT TO THE HOUSE OF DELEGATES MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA MAY, 1960—FROM BLUE SHIELD COMMITTEE—J. H. SHUFORD, M.D., CHAIRMAN

By authority of letter dated 2 June 1959 from Mr. James T. Barnes, Executive Director of the North Carolina State Medical Society, the Blue Shield Committee membership consisted of the following members:

W. Z. Bradford, M.D.
W. C. Goley, M.D.
W. H. Flythe, M.D.
J. R. Hoskins, M. D.
J. A. Howell, M.D.

L. L. Klostermyer, MD. (Co-Chairman)
J. W. Morris, M.D.
L. C. Roberts, M.D.
M. P. Rogers, M.D.
J. H. Shuford, M.D., Chairman

The whole Committee met a total of three times. Three professional subcommittee meetings were also held by Districts. The Chairman attended the Blue Shield National Professional Relations Conference in Chicago, Illinois. The Committee attended to such routine matters as review of special cases, adjudication of claims, and some minor changes in the Doctors Program Service Plan nomenclature and fee schedule. At the present time, there are approximately 125,000 persons covered under the Doctors Program Service Plan.

One thousand seven hundred doctors participate in the Doctors Program, and this is approximately 55% of the physicians in active private practice. It is hoped that the appointment of Blue Shield physician consultants in each county (see the fourth paragraph on page 2) and better liaison will increase participation in the near future. The Committee, feeling that the public is entitled to know who is participating and that participating physicians are entitled to some recognition, unanimously voted to authorize Hospital Saving Association to release the names of participating physicians to any subscribers or

prospective subscribers who may request such information. This action was taken solely in the interest of fairness to the public.

Further efforts are being made to incorporate into the Doctors Program Service Plan some fee schedule pertaining directly to Internal Medicine. This project is under study and has not yet been fully developed.

The Senior Certificate, as authorized by the House of Delegates at the 1959 Annual Meeting, has been placed on sale and is receiving acceptance throughout the entire state. Hospital Saving Association statistics reveal that approximately 800 persons are now covered by the Senior Certificate. Further advertisement and salesmanship should increase the coverage for our older citizens. The Committee feels that the development and sale of the Senior Certificate has created one of the most potent bulwarks against Federal intervention in the practice of Medicine. (EXHIBIT 1)

At the request and with the cooperation of the North Carolina Dental Society, and by authorization of the House of Delegates of the North Carolina State Medical Society, an Oral Surgical Rider has been developed. This Rider has been approved by the Executive Committee of the Dental Society, the Blue Shield Committee, and the Board of Trustees of Hospital Saving Association. The Oral Surgical Rider is now available to the public on a voluntary basis and with a separate premium. (EXHIBIT 2)

The Committee has been continually perturbed concerning the ever increasing rate of utilization, and possible needless hospitalization occurring throughout the state. Several methods have been used in an attempt to minimize this threat to the entire prepayment program. Letters have been sent to all Chiefs of Staff and Hospital Administrators drawing their attention to the responsibility, at local levels, to set up some form of control. They were asked to seriously consider the problem, as it might endanger and jeopardize our entire concept of Voluntary Prepaid Health Insurance. (EXHIBIT 3)

In addition, Hospital Saving Association has developed an Extended Benefits Endorsement which is liberal in its outpatient benefits. This Endorsement was further liberalized effective March 1, 1960, and will be available to both group and non-group members. Statistics show that 65,000 persons are already participating in this Endorsement. The Committee feels that the Extended Benefits Endorsement may partially solve the problem of needless hospitalization, as used to obtain diagnostic studies. (EXHIBIT 4)

Efforts to establish and coordinate the District Subcommittees on Blue Shield were found to be difficult due to the long distances involved, and lack of communication. The Committee feels that the problem of presenting Blue Shield at a local level may best be solved by securing one phy-

sician Blue Shield consultant in each county to carry out this function. This program is in the process of being developed. Slides and other material are being prepared for use by these county consultants. (EXHIBIT 5)

By action of the House of Delegates on 5 May 1958, Hospital Care Association of Durham, North Carolina, was approved to administer and sell the Doctors Program Service Plan under exactly the same conditions as Hospital Saving Association of Chapel Hill, North Carolina. Due to failure of the Hospital Care Association to change its corporate structure to give Medical Society elected Trustees a vote on the election of lay Trustees, this privilege was not exercised by Hospital Care Association.

This variance in the manner of electing the lay members of the Board has now been changed to conform with the requirement of the House of Delegates, and the Executive Council on 31 January 1960 approved the request of Hospital Care to be allowed now to proceed with sale of the Doctors Program. Hospital Care Association has applied to the National Association of Blue Shield Plans for recognition as a Blue Shield Plan.

I wish to thank the members of the Blue Shield Committee and the representatives of Blue Cross and Blue Shield for their dedication, loyalty, and help in furthering the cause of Prepaid Voluntary Health Insurance in the State of North Carolina. It is our only hope and should receive the support of every Doctor interested in preserving the American Medical Way of Life.

Respectfully submitted,
J. H. Shuford, M.D.
Chairman

February 18, 1960

Dr. Riley E. Spoon, Jr.
Suite 203
Professional Building
Winston-Salem, North Carolina
Dear Dr. Spoon:

With further reference to Mr. Beeston's recent letter, this is to officially inform you about our Trustee action at our Annual Meeting January 27th in regard to the new Oral Surgery Endorsement.

Our Trustees approved the action of your Executive Committee with the following clarification.

Our Board action was in accordance with the understanding that the fees and procedures listed have been mutually approved by the North Carolina Dental Society and the Medical Society of the State of North Carolina. Likewise, changes in the future, if any, would be made after clearance with both of the above Societies and of course, subject to approval of our Board of Trustees with particular reference to subsequent rating.

A copy of the proposed endorsement is attached.

I enjoyed seeing you in Raleigh recently.

Sincerely yours,

(s) E. B. Crawford

E. B. Crawford

Executive Vice President

EBC/jl

cc: Dr. Edward U. Austin

Mr. Andrew M. Cunningham

Dr. Jacob H. Shuford

Mr. J. T. Barnes

ORAL SURGERY ENDORSEMENT

IN CONSIDERATION of the application herefor and upon payment in advance of the applicable additional subscription dues, the certificate to which this endorsement is added is hereby amended to provide the following oral surgical benefits, when such services are received following the effective date of this endorsement.

1. DEFINITIONS:

A. *Dentist* shall mean any Dentist duly licensed to practice Dentistry who, under such license, regularly charges and collects fees from patients in his own right.

B. *Oral Surgical Procedures* shall mean those surgical procedures listed in this endorsement which are performed by a Dentist as defined above.

2. BENEFITS:

A. *Oral Surgical Benefits* will be provided in accordance with the Schedule of Professional Benefits. Benefits will be allowed whether or not the procedure is performed in the hospital, in the Dentist's office, or in the home.

B. The Association will pay the Dentist's charge in full when it does not exceed the benefit set forth in the Schedule for the procedure performed and such payment shall fully discharge the Association's obligation hereunder.

3. GENERAL PROVISIONS:

A. This endorsement is a part of the certificate to which it is issued and the provisions, terms and conditions of said certificate shall apply to this endorsement except where the intent of the endorsement is plainly to the contrary.

B. All services customarily performed by dentists, except those specifically included in the definition of Oral Surgical Procedures in Paragraph 1, B above are conclusively excluded from the benefits of this endorsement.

C. Fees listed as IC (Individual Consideration), and for unusual cases involving listed procedures may be assigned by a committee of the North Carolina Dental Society and the Association.

SCHEDULE OF ALLOWANCES ORAL SURGICAL ENDORSEMENT

Maxillofacial Bones

1513	Incision of soft tissue, abscess from osteomyelitis	15.00
0572	Excision of cystic or soft lesion of maxilla or mandible without bone graft (simple)	25.00
	extensive	100.00
0571	Excision of cystic or soft lesion of maxilla or mandible and filling of defect with bone graft chips (extensive with or without internal fixation)	150.00
0573	Partial ostectomy (excluding alveolar process)	
	a. mandible or maxilla	50.00
0611	Osteoplasty, shortening or lengthening of mandible (by report)	200.00
1913	Biopsy, bone maxillo-facial	25.00
	Jaw Fractures	
0696	Maxilla. simple, no displacement, closed reduction	50.00
0697	simple, with displacement, closed reduction	50.00
0698	compound	75.00
0700	simple or compound, open reduction complicated with transantral approach	100.00
	complicated with head cast and external traction	125.00
0703	Mandible, simple or compound, closed reduction without wiring of teeth	30.00
0704	simple or compound, closed reduction with wiring of teeth	50.00
0705	simple or compound, open reduction	100.00
0706	skeletal pinning with external fixation	50.00
	Joints	
1054	Temporomandibular joint, injection of, hypermobility, initial	10.00
1055	subsequent, maximum of three	5.00
1088	Condylectomy or excision temporomandibular joint	IC
1251	Dislocation, temporomandibular, closed reduction	15.00
	Muscles	
1441	Drainage of abscess or infection of muscle of oral cavity up to	15.00
1911	Biopsy, soft tissue, gingival, buccal mucosa or palate	10.00
	Accessory Sinuses	
2031	Closure of dental fistula of maxillary sinus with flap	100.00
	Removal of root tips from maxillary sinuses (intra-oral)	75.00
	Digestive System—Mouth	
2705	Drainage of Ludwig's angina	IC
2711	Excision of benign lesion of gingival or buccal mucosa up to	25.00
	Tongue	
2770	Excision superior or inferior labia frenum	25.00
2774	Removal of foreign body from tongue arising from dental injury	IC
2777	Repair of traumatic injury of tongue	IC

Palate and Uvula

2884 Excision of torus palatine or mandible	
simple	25.00
multiple	50.00

Salivary Glands and Ducts

2924 Excision of ranula	50.00
Removal of Impacted Teeth	
2825 Soft tissue	10.00
2827 Bone impactions	20.00

Subsequent impactions at same sitting 50% each additional. Unusual and complicated cases given special consideration based on a special report.

Radiation Services

7111 X-rays for traumatic injury up to	10.00
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The Association has, by its Officers duly authorized in that behalf, issued this endorsement to the Subscriber whose name and certificate number appear on the Identification Card issued to such Subscriber.

Dear Doctor:

We believe it has become vitally necessary to secure the active cooperation of physicians and hospitals on an organized cooperative basis to lower the over-all cost of prepaid health coverage. The DANGER, and it is a real danger, is that increased costs due to unnecessary utilization, or misuse of health facilities will precipitate government intervention and control. The pending Forand Bill is merely a first major skirmish in the issue of medicine by government versus private practice and voluntary health insurance. Expanded use of hospital facilities because of progress in medical science and necessary increased costs due to higher commodity prices and wages can be understood and accepted by the public.

The problem can not be solved alone by business, the Association, the medical profession, or hospitals. However, we believe it can be solved if we act together. Physicians, of course, occupy a key role because they have sole responsibility for admission, medical services, and discharge of patients.

We have sent your hospital the customary "Breakdown of Services" as shown by our payments for in-patient services for the period January 1 through June 30 together with a cover letter outlining these same problems. This is a statewide approach even though separate sections of the State may vary widely. We feel we should alert all to the problem even though some areas are better than others.

Please accept this as it is intended—a sincere request for cooperation concerning a problem of mutual importance. We know that results may not be easy to obtain. Established and customary procedures may be difficult to change. Patient pressure may be great.

We would appreciate it very much if you would devote one of your next meetings to a discussion

of costs and utilization even though your area may not be unusual. Attached are some ideas which may not be applicable in all cases, but some of which might be possible in your area.

We hope that voluntary elimination of waste of community funds, if any, will convince everyone there is no need for outside interference.

We will be glad to work with you and try to supply you and your hospital with any additional information you may want. We will much appreciate your comments and ideas.

Sincerely,

(s) E. B. Crawford

E. B. Crawford

Executive Vice President

To The Administrator of the Hospital Addressed:

We are again glad to send you the Breakdown of Services as shown by our payments to you for the period January through June, 1959.

You probably already know that in many states Blue Cross Plans have had serious trouble during Insurance Department Hearings for rate increases. There has been organized opposition to these needed increases from labor leaders, a few politicians and some special groups resulting in some unfavorable comments about costs and hospital and physician partnership with Blue Cross and Blue Shield. As you know, costs, affecting rates, are based on two things, the rate of admission and the cost of the services themselves including length of stay. The hearings, in other states, have led some Insurance Commissioners to approve lower rates than requested, on the assumption that the difference should come from such things as lower charges, less frequent usage, including better admission and discharge procedures, etc.

We have been fortunate in our State not to have had such pressure and its subsequent unfavorable publicity. We believe this is largely due to the fine cooperation between the Hospital Association, the Medical Society and Hospital Saving Association. It is with this type of cooperation in mind that we bring certain matters to your attention.

We have had to increase rates in over 60 counties in the State and we would fail in our obligation to you and your medical staff unless we alerted you to the fact that many businessmen are questioning our increases on the grounds that more responsibility in over-all costs should be assumed by others and not just by the people alone. Our answer is that we are asking hospitals and physicians to analyze their areas of cost control. At the same time we are requesting these business leaders to distribute information to their own employees about their own pressure for unnecessary usage.

Since the doctor plays such a key role in all of this, we are sending you and your Chief of Staff some pertinent data relating to the whole problem. This is not intended to be critical; in

fact, in some areas, we know the facts will need appreciative comments; but we hope it points up some factors that we should all consider for the future welfare and progress of the voluntary prepayment program in our State. We know much of this is very difficult to solve and for this reason we hope you will understand we are trying to secure consideration from all in ways and means to assume mutual responsibilities. We are more than anxious to do our part.

Sincerely,

(s) E. B. Crawford

E. B. Crawford

Executive Vice President

SOME FACTORS IN EFFICIENT USE OF MEDICAL FACILITIES AT MINIMUM COST

1. No admission of patients who could readily be treated on an ambulatory basis.

Note: Copy of Article III, paragraph 11, d. of Hospital Saving Association Blue Cross certificate:

"d. Hospital benefits are available only to persons who are ill. No hospital benefits shall be provided for hospital admissions primarily for diagnostic X-ray examinations, laboratory or pathological examinations or other diagnostic studies, or primarily for physical therapy, for causes which could be, and generally are, treated on an ambulatory basis."

2. Resistance to patient pressure for studies not related to the diagnosis, but secured because Blue Cross lists the services as a benefit.

Note: Copy of Article II, 3, a:

"3. General

- a. Benefits under Article II will be granted only if the designated services are consistent with the diagnosis and treatment of the condition for which hospitalization is approved. All of the items listed must be services or materials furnished the participant as a routine part of the operating costs of the particular hospital and used by the patient, while in the hospital. (Also see Article III, 11, f.)"

The above are positive exclusions in our Blue Cross certificates, but very hard to administer without physician cooperation.

3. Surgical admissions geared to pre-operative tests and operating room schedule, saving pre-operative days—weekends, etc.
4. Proper stop orders on medication.
5. Medication only for hospital use—not take-home medicines charged to Blue Cross.
6. Patient advised of discharge hour in time to notify family, avoiding extra days in hospital.
7. Patient discharged as soon as medically correct—avoiding longer stays, weekends, etc.

for convenience rather than need.

8. Honest resistance to patient pressure for admission for convenience *because* they have Blue Cross.
9. Staff and Hospital Administration work together on standardization of drugs so as to conserve hospital drug inventory (not succumb to drug salesmen pressure for "new names"—causing hospital inventory to be wasted).
10. Continuous and serious analysis of over-all hospital operating costs.

HOSPITAL SAVINGS ASSOCIATION OBLIGATIONS

1. Impress on the public through advertising, company bulletin board notices, billing notices, stuffers, etc., both the reasons for increased cost of superior medical care for necessary services and the danger of added cost resulting from demands for non-essential hospital services.
2. Careful underwriting.
3. Clear certificate provisions—exclusions as well as benefits.
4. Presentation of statistical data to member hospitals and staffs relating to unusual utilization or costs in specific areas.
5. Join hospital and medical staffs to help secure more public funds for indigent care—at hospital costs.
6. Extension of sound coverage whenever possible through out-patient endorsements to replace in-patient admissions. (See our Extended Benefits.)

FREQUENCY OF INPATIENT HOSPITAL ADMISSIONS

	1957	1958
North Carolina—All Patients*		
Per 1,000 Population	126	
United States*—All Patients		
Per 1,000 Population	123	
Blue Cross—United States		
Per 1,000 Participants	136	140
Blue Cross—North Carolina (Hospital Saving Association)		
Per 1,000 Participants	153	160

*Source: Journal American Hospital Association (Short Term General and Special Hospitals) 1957 latest figures available.

PRE-PAID MEDICAL CARE

What They Are Doing.

Edited by

RICHARD J. ACKART, M.D.

The cost of health services projected by the rate of utilization of those services equals money out of people's pocketbooks. Twenty-five years ago the persons who were truly concerned with this "axiom", those persons whose pocketbooks were involved, were the relatively few individuals who had occasion to use health services. Even at

the relatively low costs and utilization rates then existent, many of these individuals had their pocketbooks depleted when meeting the expense of the health services they needed. The situation called for corrective action, and the doctors and hospitals across the country established Blue Cross-Blue Shield Plans to provide it—they adapted the “spread-the-risk” principle to the field of health-care expense, establishing non-profit, community, service organizations to run the “business”.

During the ensuing quarter century, spreading the risk of health-care expense became “big business”. Each year saw an increasing number of people subscribing to the idea of periodically paying small amounts into a “pool” from which would be paid the large amounts needed to cover the health-care expenses of those participants who became sick or injured. Today three-quarters of the population participate in a “spread-the-risk” plan of some kind, and today the “axiom” involves not only the people who have need of health services but just about everybody. Because of participation in some spread-the-risk plan, just about everybody, the healthy as well as the sick finds his pocketbook is affected by changes in the cost of health services and by changes in the rate of utilization of those services. Just about everybody is understandably perturbed that the now precipitously rising costs and utilization rates are hurting him in the pocketbook.

The people of several states, through their governments or other agencies, are taking a close look at just how health services are provided and used. This is what they are doing.

Kansas:

Joint Committee of Blue Cross-Blue Shield, Kansas Hospital Association, and Kansas Medical Society has initiated a study on Utilization of Hospital Facilities which is being conducted by the medical staffs of approximately 100 hospitals throughout the State. Its purpose is to develop a way for medical staffs to routinely evaluate a sample of cases for the detection of possible faulty usage. This study has been in progress since September 1958 and should be completed in the near future.

Massachusetts:

A dual study has been undertaken by the Blue Cross Plan and the Massachusetts Hospital Association, and has been under way since late last summer. Phase 1, conducted by the Blue Cross Plan, is a study of the cost of hospital services extended to Blue Cross member patients as compared to the costs of services rendered to non-Blue Cross patients. It is estimated that this phase will take about 15 months to complete and will cost approximately \$50,000. Phase 2 is designed to ascertain the non-medical factors and

family situations which lead to hospital utilization, as well as the medical reasons for such admissions given by attending physicians. This phase will be conducted by the Health Information Foundation in conjunction with the National Opinion Research Center of the University of Chicago. This project, which will cost about \$200,000, is to be paid for by the Health Information Foundation and is under the direction of Odin W. Anderson, Ph.D., of HIF and Paul S. Sheatsley of NORC. This phase has the active support of the Massachusetts Medical Society, Massachusetts Hospital Association, and the Blue Cross-Blue Shield Plans.

Michigan:

An outgrowth of hearings held by the Governor's Study Commission on prepaid hospital care plans, a detailed study was started last year by the University of Michigan. Its anticipated cost is \$325,000 which will be contributed by the W. K. Kellogg Company; the project director is Prof. Walter J. McNerney, Director, Programs in Hospital Administration, University of Michigan. With the active support of the Michigan State Medical Society, Michigan Hospital Association, and Michigan Blue Cross Plan, the project is on a state-wide basis and is designed to cover the following major areas:

- (1) Physician influences on hospital utilization.
- (2) Household survey to determine means of financing, and attitudes toward, medical expenses.
- (3) Hospital accounting and reimbursement.
- (4) Insurability of hospital services, cost trends, and related factors.
- (5) Prepayment and insurance agencies.
- (6) The effect of controls exerted by various agencies on quantity, quality and cost of health services.
- (7) Discharge (case) study.
- (8) The roles of government agencies in providing or financing health care.

New Jersey:

Instigated in mid-1958 by Charles R. Howell, New Jersey Commissioner of Banking and Insurance, a study is being conducted by a Citizens Committee. Primarily concerned with utilization of hospital facilities and its relation to Blue Cross rates, the study is believed to have been instigated in response to labor group pressure following hearings on Blue Cross rate increases in March 1958. The exploratory work is being conducted by Dr. Sidney I. Simon of Rutgers University and indications are that the following areas will be studied:

- (1) Availability of hospital facilities.
- (2) Hospital Costs.
- (3) Utilization of hospital facilities.
- (4) Blue Cross payments to hospitals.

- (5) Blue Cross reserves.
- (6) Blue Cross administration.

New York:

Requested by the Superintendent of Insurance, a study is being conducted by Columbia University School of Public Health and Administrative Medicine under the direction of Ray E. Trussell, M.D., Associate Dean. Its cost, about \$150,000, is to be financed by the 19 non-profit health insurance plans in the State, including eight Blue Cross Plans, in proportion to their total respective annual incomes. Designed to provide a basis for the determination of fair and equitable rates for prepayment, the study will cover these areas:

- (1) Historical development and public purpose of the non-profit plans.
- (2) Operations of hospitals.
- (3) Hospital reimbursement cost formulas.
- (4) Utilization of hospital facilities and trends in their use.
- (5) Financial structure of plans including operating costs and benefit provisions.
- (6) Legal handicaps.
- (7) Experience rating versus community rating.
- (8) Representation on Boards of Directors.

Ohio:

Just under way is a study by the State Department of Insurance which has requested that hospital costs and the utilization of hospital facilities be investigated in the 15 counties served by the Cincinnati Blue Cross Plan. Initially, a series of questions by the Department has been sent to all Ohio Blue Cross Plans and it is planned to present an outline for the study to a special committee of the Hospital Advisory Council.

The Cleveland Blue Cross Plan is bringing to completion a study which has been under way for three years. Limited to the five counties that made up the original operating area of the Cleveland Plan, the survey is being conducted by Howard Whipple Green and Associates. Its estimated cost is \$150,000 and its areas of study are Availability of Hospital Facilities, Hospital Costs, and Utilization of Hospital Facilities.

Pennsylvania:

The Governor has appointed a 43 member commission under the chairmanship of State Insurance Commissioner Francis R. Smith to study:

- (1) Availability of hospital facilities.
- (2) Hospital costs.
- (3) Utilization of hospital facilities.
- (4) Blue Cross payments to hospitals.
- (5) Blue Cross reserves.
- (6) Blue Cross administration.

Still in the planning stage, it is expected that this study will also embrace problems of hospital

administration, government subsidies for free care, clinic and outpatient methods, and fees for the care of long-stay and convalescent patients. It is estimated that this study will require at least two years to complete and will cost about \$300,000; to be financed by the State, the five Blue Cross Plans, and other organizations.

BLUE SHIELD CONSULTANTS

Physician Consultants from County Medical Societies to the Blue Shield Committee of the State Medical Society

Because North Carolina is a State covering a large geographical area with one hundred counties, and thousands of small communities, it is difficult, if not impossible, for one nine-man Committee to adequately represent all physicians and all segments of the population. Because the political climate dictates the fullest expansion of voluntary health insurance and because non-profit Blue Shield Plans are the only type of insurance controlled by the Medical Profession, it is essential that all active practicing physicians understand present problems and opportunities and have a direct voice in the operation of their Blue Shield Plan. Therefore, the Blue Shield Committee appointed by the State Medical Society shall appoint one or more physicians in each County Medical Society with the following RESPONSIBILITIES, AUTHORITY and PRIVILEGES:

1. The County Medical Society Blue Shield Consultant shall be a physician engaged in the active practice of medicine who is a participating physician in the Blue Shield Plan. He shall be a recognized leader in the professional and civic life of the community.
2. The Blue Shield Consultant will receive from the Blue Shield Committee and its Secretary all up-to-date information concerning Blue Shield developments on both a State and National basis, including Committee Minutes.
3. The Consultant will endeavor to arrange at least one annual meeting of the County Medical Society devoted to a discussion of Blue Shield.
4. The Consultant will receive any grievances or complaints and refer them to the Blue Shield Committee with his recommendation. The Consultant will have the privilege of attending meetings of the Blue Shield Committee by prior arrangement with the Chairman for consideration of any grievances or suggestions arising within the county.
5. The Blue Shield Committee when considering individual claims for evaluation will have the privilege of referring a claim to the Consultant for recommendation and a determination as to customary charges and practices within the county.
6. The Consultant will be supplied with any

pertinent data concerning participation, enrollment, and loss ratios within his county.

7. When the Blue Shield Committee believes that changes in the Plan may be desirable, the Consultant will explain the proposed change to his County Medical Society, determine the reaction of County Medical Society members, and relate the information to the Chairman.
8. The Blue Shield Committee shall have at least one annual meeting to which all Consultants will be invited.
9. Blue Shield Committee members necessarily represent the entire Medical Society membership and all citizens. Consultants are concerned with a limited area. Therefore, a Consultant may be appointed even in those counties currently represented by a Committee member.
10. Two or more Consultants may be appointed from the same county when a county has two or more sizable population centers served by hospitals in different geographic areas.

For the Committee

Jacob H. Shuford, M.D., Chairman

(Unanimously approved by the entire Committee at its meeting of March 24, 1960.)

COMMITTEE ADVISORY TO THE AUXILIARY AND ARCHIVES OF MEDICAL SOCIETY HISTORY

This Committee has had two meetings during the year and your Chairman has been in frequent contact with the President and Officers of the Auxiliary throughout the year. In addition to the various projects being carried on by the Auxiliary your Committee is particularly glad to report that a great deal of time and effort was given to Legislation, A.M.E.F., Student Loan and Mental Health.

Your Committee is particularly pleased with the untiring efforts of the President, Mrs. Robert L. Garrard, in her plan to set up a mental health endowment fund similar to the tuberculosis bed endowment fund. Inasmuch as the activities of the tuberculosis bed endowment fund is greatly minimized, Mrs. Garrard spearheaded a plan to raise funds for this new endowment project. Instead of using the proceeds to care for a few hospitalized patients, the proceeds from the new endowment fund will be used for a training and research program in the psychiatric department of the North Carolina Memorial Hospital, University of North Carolina, Chapel Hill.

The Program hopes to attack mental illness in three major areas:

1. Training of medical and allied personnel.
2. Research in mental disorders.
3. Improve patient care.

Your Committee feels that this is a major step

towards attacking mental illness in North Carolina.

The Committee suggests the Auxiliary rewrite its Constitution and By-Laws, with the help of the Medical Society Attorney. The Committee has appointed a Sub-Committee to work with the Auxiliary Treasurer to have the Auxiliary trust funds evaluated to investigate the possibility of increasing earned income. We recommend the Auxiliary dues be increased from one dollar to two dollars.

ARCHIVES OF MEDICAL SOCIETY HISTORY

The Committee has become increasingly aware of the valuable contribution which has been made to the profession by many North Carolina physicians; and that many medical "firsts" have been achieved in the State. Realizing that many important records and memories would be lost unless the Society took prompt action, your Chairman has appointed the following Sub-Committees to compile historical records:

1. History of the North Carolina State Board of Medical Examiners.
2. History of the Blue Cross and Blue Shield.
3. History of Tuberculosis.
4. History of Radiology.
5. History of Obstetrics.
6. History of Post Graduate Work.
7. History of Surgery.
8. History of the Auxiliary.
9. History of North Carolina Medical Education.
10. History of Public Health.
11. History of Medical Care Commission.
12. History of Academy of General Practice.
13. History of County Medical Societies.

These Sub-Committees have done valuable work and are continuing to do so, but much still remains to be done.

Since this is a long range project a more detailed report will be made at a later date.

/s/ Roscoe D. McMillan, M.D.
Chairman

COMMITTEE ADVISORY TO NORTH CAROLINA STATE BOARD OF PUBLIC WELFARE

Your Committee to advise with the State Board of Public Welfare has had only one official meeting with Dr. Ellen Winston, Commissioner of Public Welfare, and members of her staff during the present fiscal year. That meeting was held in the Sir Walter Hotel in Raleigh, North Carolina, on the afternoon of November 22, 1959. Only your Chairman and Dr. A. B. Choate and Dr. Bruce Blackmon, members of the Committee were able to be present. Mr. James T. Barnes and Mrs. Annette Boutwell from the Medical Society were present. Dr. Raney Stanford was a special guest, invited to discuss matters relative to the cost of hospitalization of indigent persons. Since this meeting your Chairman and Mr. James T. Barnes, Executive Director of the Society, have met with Dr. Winston and other members of the Society

in an informal discussion of various problems of interest to the Medical Society and the State Board of Public Welfare.

At the above mentioned meeting of November 22nd a number of matters of mutual interest were reviewed. It seems that these matters in which we are jointly interested are constantly present from year to year. But in the light of changing times they need to be frequently reviewed and clarified. I will mention a few of the items that were discussed.

The problems concerning procedures with regard to examinations for the disability determination program were discussed. Dr. Nelson Thompson of the State Board of Public Welfare staff pointed out procedures of authorizing consultative examination. It was suggested that the Department of Public Welfare and the Public Relations Division of the Medical Society make every effort to see that doctors are informed about these procedures.

The question of a provision for drugs for indigent persons was discussed. It was reported by Dr. Winston that the cost of drugs for these people varies from county to county and oft times from store to store in the same city. There has been some complaint from drug stores that the State Board of Health has been furnishing drugs to persons discharged from some of our state institutions who are able to buy their own medicines. It was suggested that the Department of Public Welfare discuss the matter of cost of drugs with the officers of the North Carolina Pharmaceutical Association.

Briefly I will mention that some old problems are still with us. There are still some two or three doctors in our State who refuse to abide by the law and are assisting in the adoption of children illegally. Your Advisory Committee wishes to point out that it is incumbent upon all people, and particularly those who, like physicians are before the public eye, to obey the laws whether they agree with the mor not. The problem of illegitimacy is also still with us as it is with almost every State in the Union. Perhaps some day we will find the answer to this problem that has haunted society almost from the beginning of recorded history.

A matter of immediate concern to the people of North Carolina, to the State Board of Public Welfare, administrative officers of our various governmental units such as counties and cities, the Hospital Association, and the Medical Society is the ever rising cost of hospital care. The problem that concerns us and the above mentioned groups is how to pay the cost of this care. As Dr. Raney Stanford said, this is the only phase of the Good Health Program of a decade and a half ago that has not been implemented enthusiastically. Payment to hospitals for this care in most cases lacks many dollars of meeting the per diem cost. Your Committee representatives and the Executive Director of the Society mem-

bers of the Legislative Committee, and the President-Elect have had two or more meetings to discuss methods of implementing this last phase of the Good Health Program. Dr. Raney Stanford of Durham has devoted a good deal of study to the problem, is well informed on it and has given and is giving generously of his time working toward finding a solution to this problem. I think I should point out here that if we could get the State of North Carolina to assume what we think is a proper share of the cost of indigent care, we could solve this problem. For example; in the Pool Fund Group the Federal government pays 65 cents out of each dollar, the State government 17½ cents and the county 17½ cents. In addition, the counties in North Carolina are spending 2½ million dollars annually for indigent care and for that get help neither from the Federal government or the State Government. The money seems to be available from the Federal government and from the local governments and, therefore, for every 17½ cents additionally the State of North Carolina will provide, welfare departments could pay the hospitals one dollar more toward the cost of indigent care.

Now finally, may I as Chairman of your Committee, urge that our Medical Society continue its present relationship with the State Board of Public Welfare through the Advisory Committee. It is important for the Society as physicians to know what is going on in a medical way in the welfare department. Likewise, it is worthwhile and a benefit to the State Board of Public Welfare to have the advice and the approval, and, sometimes the criticism, of the Committee from the State Medical Society. Our relationship to date has been most friendly and cooperative with each other. I must point out, however, that recently we have not had good attendance from the members of the Advisory Committee. It is, therefore suggested that the administrative officers of the Society make every effort to see that all members appointed to this Committee have an interest in medical and welfare problems and are willing to give of their time that the Medical Society, the Public Welfare Department, and the public in general may benefit from their efforts.

/s/ J. Street Brewer, M.D.
Chairman

COMMITTEE ON CHILD HEALTH

The work of the Child Health Committee has been confined to the continuation of the project of the Neonatal Death Study Committee which has been carried on for several years under the combined auspices of the Child Health Committee and the Maternal Welfare Committee.

It has been decided at the September 26, 1959 meeting of the Committee in Pinehurst that the survey which had previously included only those Clinics and Hospitals delivering more than 100 children annually should be broadened in 1960 to include all births in the State on which it was

possible to secure data. This type study is now in progress for 1960. We hope to collect data on all births including those delivered by individual practitioners and also those delivered by midwives. This is a very difficult procedure and the Committee requests the continuing cooperation of all physicians who are doing obstetrics and pediatrics in North Carolina.

The Committee is especially appreciative of Dr. Charles Williams' work in acting as secretary of the Neonatal Death Study Committee. Without his excellent work, it would be impossible to continue this study.

/s/ Angus M. McBryde, M.D.
Chairman

COMMITTEE ON CHRONIC ILLNESS

The State Committee has held three meetings during the year, two meetings with the Joint Committee for the Health Care of the Chronically Ill and Aging, sponsored one workshop meeting for county chairmen, and has cooperated with other committees of the State Society, the A.M.A. Council on Medical Service, A.M.A. Committee on Aging, and various other national, regional, and state organizations in promoting opposition to Forand type Legislation and encouraging individual, community, and state responsibilities for the adequate health care of the chronically ill and aging.

With the primary emphasis given this year to the problems of the aging in lieu of national legislation proposed; the 1960 Governor's Conference on Aging, and the 1961 White House Conference on Aging, the Committee has spent most of its time and efforts towards these means yet not omitting its interest in the areas of chronic illness.

The Committee has Worked Toward the Following Objectives to:

1. Stimulate interest and promote understanding among physicians as to the needs of our older citizens and solicit their participation in serving with community leaders to give guidance and leadership to find practical ways and means of meeting current and future problems related to both the aging population and the chronically ill.
2. Cooperate with the coordinate programs and services of state agencies, professional organizations, and volunteer groups interested in studying and evaluating present facilities and services provided the chronically ill and aging and encouraging improvement of standards.
3. Continue to seek improvement and expansion of voluntary insurance programs and continue opposition to Forand type Legislation.
4. Cooperate with and encourage state agencies and other groups sponsoring "demonstration projects" surveys, or community evaluation of current facilities and services and to encourage physician participation in community and state

planning programs to improve the care of the chronically ill and aging.

5. Sponsor and cooperate with research programs designed to study and make recommendations as to needs of these two groups.
6. Cooperate with the Council on Medical Service and its Committee on Aging.
7. Continue to explore problems concerned with the medical, biological, and sociological aspects of aging and chronically ill.

Major Activities of the Committee:

1. Contact with County Chairmen:

The State Committee has encouraged county societies to appoint county chairmen to help coordinate activities and information at the local level. Committee minutes and special reports have been disseminated to county chairmen, especially in regard to their action opposing the Forand type Legislation. County societies have responded by sending Resolutions to the N. C. Congressmen and Senators, members of the House Ways and Means Committee, and have solicited similar action from other interested business and civic organizations at the local level.

County chairmen have been encouraged to study their own resources for the care of the chronically ill and aging and to work with existing agencies and organizations for improvement of standards for facilities and services and to coordinate local efforts in providing the best care possible for the chronically ill and aging.

The state committee and county chairmen have worked closely with the legislative committee in an all-out effort opposing Forand type of National Legislation and has consistently pointed up the gaps and inadequacies of such a program in meeting present or future needs.

2. Joint Committee for the Health Care of the Chronically Ill and Aging:

The state committee has continued its sponsorship and leadership to the Joint Committee functions. Two meetings have been held during the year at which time reports were given on existing programs, demonstration projects, special conferences attended and participation by members, and has encouraged more and more attention to be given to an expanded home care program. Through these joint meetings, state and volunteer agencies exchange ideas, progress and problems, and together make recommendations for improvement of present facilities and services. The Joint Committee serves as a clearing house for information and gives opportunity for open discussion and a better understanding of state and local programs.

3. Cooperation and Participation in the 1960 Governor's Conference on Aging:

Through the close cooperation and coordination of the Joint Committee, the Chronic Ill-

ness Committee was requested to suggest key physicians and lay representatives to serve on the Governor's Conference Planning and Study Committees. As a result, practicing physicians have been named to seven of the eight sub-study committees, with recommended lay representatives serving on all eight committees. There has been a very close working relationship between the Governor's Committee Chairman and the Medical Society's Committee on Chronic Illness.

4. Cooperation and Support of "Demonstration Projects for Home Care Services".

Progress reports have been made to state committee members and to county chairmen on local demonstration program on home care; such as the Person County Study, now in its second year of operation, a new program in Alamance County, and the Home-maker Service Program now operating in nine North Carolina Counties. The rural demonstrations in three counties sponsored by the Welfare Dept. has been reported successful. Increased emphasis has been given to Homecare Programs as the greatest need for our chronically ill and aging. The Guilford County Survey of 1957-58 pointed to this area as being the most important service needed and the results in Person and Alamance Counties have proved this to be correct.

In Greensboro the Community Service Council has developed an organization with three sub-committees: 1. Organized Home Care Program, 2. Rehabilitation, and 3. Coordination of Medical Care Services and Occupational Needs of the Chronically Ill patients. The Coordination of Medical Care Services and the Home Committees were combined into one Committee to plan the organization of a program serving as combination chronic illness information center and organized home care service. The family physician will make all referrals and continue supervision of his patient in which he is being aided by this organization of services. Functions of the planned organization are:

1. To provide an organization having centralized responsibility for administration and coordination of services to patients and providing medical, social and nursing services.
2. To collect and maintain current information on available community facilities and agencies offering service to the chronically ill and/or aged.
3. To provide referral services to individuals seeking an appropriate service.
4. To provide team work planning between agencies giving a service to the chronically ill, in order that such services will not be duplicated, gaps can be recognized and (hopefully) services be made available to fill these needs.

The Committee has also been interested in local hospitals establishing "progressive care" programs in an effort to reduce the cost of hospitalization and medical care and in shortening the length of hospital stay where you have adequate community services to assist with home care and out-patient services.

5. Support of the 1959 legislation related to the health and medical care of the indigent and medically indigent.

The State Committee supported the following legislative actions.

1. The "pooled" hospital fund was increased to permit an increase in payments from \$8.50 per day to \$10.00.
2. Permission was given counties to pay out-of-state hospitals from the pooled hospitalization fund.
3. As of January 1, 1960, all homes caring for the aged must be licensed.

Other proposals included; but not acted upon were:

1. State General Assistance Fund to assist the medically indigent on a matching basis with county funds.
2. Increased appropriation for the Medical Care Commission which at present pays \$1.50 per day for medically indigent hospitalization.

A most pressing need is for increased facilities for negroes needing skilled nursing care. North Carolina has less than 100 licensed negro boarding homes and the need is increasing just as it is for white residents—be it domiciliary or skilled nursing care. An approach has been made to the negro hospitals to see if they would consider the possibility of using unoccupied hospital beds for patients needing skilled nursing care under medical supervision.

6. Increased hospital facilities:

At the end of 1959, the Medical Care Commission has approved contributions involving Federal and State funds in a total of 318 projects to provide improved medical facilities throughout the State at a cost of \$151 million. Of these, 258 projects have been completed; 35 are under construction; and 25 are in the planning state. Since 1947, North Carolina has an increase of 8,097 total hospital beds, giving a total as of Dec. 1959 of 17,108 beds. Five chronic disease projects have been approved for a total of 351 beds.

North Carolina continues to rank first in the total number of projects approved under the Hill-Burton Act, fourth in the number of beds, second in the number of health centers, about ninth in the total funds expended.

The Commission has proceeded cautiously to assure the accreditation only of nursing homes operated in buildings reasonably well designed for nursing services and operated by a qualified staff. It has been gratifying to

observe the gradual replacement of existing inadequate plants by modern and efficient buildings. There are now 32 facilities licensed as nursing homes under the Commission's program, providing about 1,000 beds. An additional number of modern facilities are now in planning. Of the 32 nursing homes licensed, 70 per cent employ registered graduate nurses.

A concentrated effort is being made to secure financial loans for new construction and renovation of existing facilities to meet licensure specifications.

7. The State Committee has maintained close liaison with insurance companies in encouraging extended benefits to chronically ill and aged patients. Both Blue Cross companies operating in the state now have Senior Citizens Certificates. Experience to date has proved most encouraging and it is the hope that individuals will avail themselves of this type protection. The insurance companies are to be commended for their efforts in giving extended coverage and for other protective programs which will increasingly prove of value to retired workers in the future. It is estimated that today, 70% of all persons 65 years old and older who desire insurance protection, have coverage and that by 1970, 90% of this age population will be covered with some type of health insurance protection.
8. Special studies being conducted by physicians and sponsored by the Committee on Chronic Illness:
 - a. Re-survey by county medical societies to enumerate and evaluate existing facilities for the adequate care of the chronically ill and aging. (exhibit A.)
 - b. Re-survey by member physician asking for a thirty-day account of chronically ill patients seen at least one time, condition or disease recorded, and an evaluation of the need for more adequate facilities or services for proper treatment or rehabilitation. Survey period—February 15-March 15, 1960. Purpose being to help establish a basis for future programs and services as recommended by local physicians.
 - c. Hospital Discharge Study: In cooperation with the State Board of Health and the North Carolina Hospital Association, all patients discharged from general hospitals during four selected weeks of the year are being reviewed as to:
 1. identifying data: race, age, sex
 2. length of hospital stay
 3. total hospital bill and method of payment
 4. primary diagnosis for hospitalization
 The Study to be completed within the year.
9. Attendance and participation in national, re-

gional, and statewide conferences by committee members:

- a. North Carolina was requested by A.M.A. to testify before the House Ways and Means Committee on July 13, 1959 in opposition to the Forand-type Legislation. The Chairman made the report and was accompanied to Washington, D. C. by the key legislative committee men and the Executive Director.
- b. Members of the State Committee and others of the Joint Committee attended the Joint Council for the Health Care of the Aged in Washington, D. C. on June 14-16, 1959. The Chairman was one of the program participants.
- c. The Chairman of the Committee attended the National Planning Conference for the 1961 White House Conference on Aging held in Ann Arbor, Michigan, June 24-26.
- d. The Chairman, Executive Director and Key Legislative Committee Members were invited by A.M.A. to participate in a planning conference for proposed legislative programs in St. Louis, Mo., October 1-2, 1959.
- e. Planning and participation on A.M.A. Regional Conferences: In the spring of 1959 the Chairman and the Executive Director attended a pre-conference planning session in Washington, D. C. at which time the A.M.A. Regional Conferences on Aging were discussed. The first conference was held in Salt Lake City in May, 1959 and Dr. O. David Garvin of North Carolina was one of the program participants. Again in Oct. 1959, in St. Louis, Mo., the Chairman and Executive Director met with members of the A.M.A. Committee on Aging to plan the late 1959 and early 1960 Regional Conferences. Members of the Chronic Illness Committee and of the Joint Committee have served as program participants in three of the nine regional conferences; namely, Salt Lake City, New Orleans, and Atlanta.
- f. The Chairman was invited to attend and participate in a Regional Directors Meeting for Blue Cross Programs held at Sedgefield Inn, Greensboro, in early November, 1959.
- g. Durham, N. C. was the site of a Regional Conference on Aging sponsored by the National Welfare Assembly in October, 1959. Again, the chairman and other committee members participated on the program.
- h. Representatives from the state committee and the legislative committee attended the National Welfare Assembly Annual Meeting held in New York in December, 1959.
- i. Duke University's Research Center on Aging sponsored its first Conference on Gerontology in December, 1959. Members

of the state committee attended this conference as well as the annual meeting on Gerontology held in November in Detroit, Michigan.

- j. A two-day workshop on Chronic Illness was held in Raleigh in August, 1959. The Committee Chairman and representatives assisted in the planning of the workshop program and invited George Cooley, Secretary, A.M.A. Council on Medical Service to serve as one of the consultants. Mrs. Lucille Smith, HEW, Washington, D. C., and Mrs. Yaduda of New Jersey also served as consultants. Members of the Committee attended and participated in the two-day workshop program.
- k. Representatives of the state committee and the Executive Director attended the National Health Council's Forum on Aging held in Miami, Fla. March 13-16, 1960.
- l. Prior to the annual Officers Conference held in Pinehurst in late January, 1960, the state committee held a workshop for county chairmen and other society representatives interested in the current chronic illness and aging programs being demonstrated in the state. Interest was expressed in holding similar workshop meetings by districts, areas, or counties to acquaint local physicians with some of the positive steps being taken by organized medicine and allied groups towards meeting the needs of the chronically ill and aged. An area workshop meeting is scheduled in Morganton, N. C., involving physicians from some nine counties, for late March, 1960. Also, the Surry County Medical Society is holding a meeting on March 24, 1960 at which time information as to existing facilities, services, and needs of the chronically ill and aging will be presented and discussed. Alamance County was one of the first to set up a county committee to discuss, evaluate, and plan a local action program for improved homecare services. The local committee met in 1958 and has continued to work together organizing a demonstration homecare service program with the cooperation of the local health department. The county medical society approved the project and agreed to help support it for a three year period. This project is similar to the Person County Home Care Demonstration project.
- m. Representation from the North Carolina Medical Society has been requested by the American Hospital Association to participate in a Home Care Workshop in Chicago, April 20-22, 1960. Also, the State Medical Society and the Chairman of the Chronic Illness Committee have been invited by A.M.A. to attend a planning conference on the 1961 White House Conference on Aging

in Chicago in late April, 1960.

10. The State Committee continues to cooperate and support projects designed to assist local facilities to improve standards of health care and protection; train and recruit personnel; and to explore possibilities to assist in payments for such care, be it private, indigent, or medically indigent.

It is the feeling of this committee and private practitioners across the state that increased home care services are of primary concern and importance in helping to reduce the cost of illness and infirmity. With better trained personnel, improved standards and facilities for boarding and nursing care, progressive care services in hospitals, and with cooperative action and support of individuals and community resources, the health care needs of the chronically ill and aging can best be met at home at less cost and with greater satisfaction to the patient.

The Committee therefore makes the following recommendations for the continuation of these activities:

1. Increased emphasis given to the formation and organization of local society committees on chronic illness. Encourage representation of all agencies and organizations engaged in either a service or educational program for the health care of the chronically ill and aged.
2. Continued support given other agency service programs that will assist with home care programs.
3. Recommendation to the Executive Council and the House of Delegates to continue their support of legislative requests from the State Board of Health, State Board of Public Welfare, Medical Care Commission, and specifically Governor's Commissions which have direct effect on the health care of the chronically ill and aged in North Carolina.
4. Continue giving leadership and help strengthen the cooperative efforts of the Joint Committee for the Health Care of the Chronically Ill and Aged.
5. Continue working with Insurance Companies, both Blues and Commercial for expansion of policy coverage and benefits to persons over 65.
6. Continuation of the liaison contacts of the Medical Society representatives with A.M.A., National, Regional, and State programs being planned and organized for the improved health care of those two segments of our population.
7. Maintain and encourage the leadership role already established by the Medical Society in this area of health and medical service.

/s/ John R. Kernodle, M.D.
Chairman

COMMITTEE ON MEDICAL CREDIT BUREAU

The Committee on Medical Credit Bureau met in Pinehurst, North Carolina, Saturday, September 26, 1959. Present at the meeting were: Dr. W. Howard Wilson, Chairman, Dr. Fred K. Garvey, Dr. John R. Hoskins, Dr. Moir S. Martin, Dr. Ross S. McElwee, Dr. David T. Tayloe, Dr. Jacob H. Shuford, Commissioner, K. G. Beeston, Secretary.

NEW MEMBER—The Chairman introduced and welcomed Dr. Hoskins, a new Committee Member.

IMPROVED EXPERIENCE—The Chairman cited the history of past unsatisfactory experience with some Credit Bureaus and stated that the situation had improved as evidenced by reduced complaints from doctors and by the fact that Credit Bureaus know of the Committee's work and seek guidance from the Committee.

COMMITTEE FUNCTION—It was agreed that the Committee did not, and should not, function as an approval body, but that the Committee's work enabled the Headquarters Office of the Medical Society to better assist individual physicians in selecting a locally controlled Credit Bureau meeting certain standards and properly licensed by the State Insurance Commission. It was agreed that the Committee should continue to act as a sounding board and be prepared to assist the Medical Society concerning any State Legislation relating to Credit Bureaus or Collection Agencies.

1959 EXHIBIT AND BROCHURE BASED ON EXHIBIT—The Chairman distributed a Brochure developed by the Headquarters staff of the State Medical Society based on the Committee's Exhibit at the 1959 Annual Meeting of the Medical Society.

MOTION—The Committee voted unanimously to request announcement to all doctors through the Medical Society Public Relations Bulletin of the availability of this Brochure. The Committee also voted to make information available to all doctors through the Public Relations Bulletin on bonding requirements of Collection Agencies after this information was secured from Mr. Gold, State Insurance Commissioner.

1960 EXHIBIT—Because some doctors from Eastern and Central areas of the State did not have an opportunity to see the Committee's Exhibit at the 1959 Annual Meeting in Asheville, the Committee voted to request the Medical Society to display the Exhibit again at the 1960 meeting in Raleigh.

The Chairman announced that Mr. Barnes was trying to arrange for display of the Exhibit at a future A.M.A. meeting.

The Committee unanimously expressed hearty approval of the Pinehurst September meeting of all Committees and Executive Council and requested that it be repeated in 1960.

/s/ W. Howard Wilson, M.D.
Chairman

COMMITTEE ON CREDENTIALS OF DELEGATES

The Committee on the Credentials of Delegates functioned at the 1959 annual meeting with the assistance of two members of the Medical Auxiliary, Mrs. E. T. Beddingfield and Mrs. T. T. Herring, whose work the committee wishes to recognize.

The Committee met in Pinehurst in September, 1959, and discussed possible ways of facilitating and speeding the checking of delegate credentials at the annual meeting. All delegates or alternates or substitute delegates are urged to present their official delegate card at the meeting. Consideration is being given to the use of a card file system to facilitate and speed the checking of delegate credentials at the annual meeting.

/s/ T. Tilghman Herring, M.D.
Chairman

COMMITTEE ON EMERGENCY MEDICAL AND MILITARY SERVICE

This committee met in Pinehurst, North Carolina on September 26, 1959. The committee recommended that the Society bear the cost of sending a single interested physician to the Walter Reed Army Institute of Research, at the Walter Reed Medical Center in Washington, D. C., for courses on Management of Mass Casualties. This was approved by the Society, and Dr. James Davis of Durham was selected as our representative. Dr. John T. Lloyd of Louisburg indicated his willingness to go and bear his own expenses. An opportunity was given the entire membership to attend this course through the media of our Journal and our News Bulletin. Both Dr. Davis and Dr. Lloyd indicated that they received much information, and will report to the committee, who in turn, will disseminate such information that is pertinent to the committees.

Forty-eight (48) counties now have written civil defense survival plans. These include all of the target cities within North Carolina. Additional plans have been formulated for the reception and care areas. We now have twenty-one (21) two hundred (200) bed hospital units stored at strategic points in the state. The hospital unit demonstrated in Asheville last year was also exhibited in three other cities, but further demonstration of this facility was discontinued because there was no Caretaker available at the time of their display. Members of the committee participated in Operation Alert in 1959, which was in conjunction with a national alert. This simulated attack pointed up many weaknesses in our preparedness.

The Committee wishes to call special attention to the "Fall Out Problem". It is urged that every member of the Society familiarize themselves with the plans for survival which have been formulated by students of the problem so that they will be able to take care of themselves, and advise their patients as to their care. It is pointed out

at the present time that the essential pre-requisite for survival and avoiding excessive fall out exposure is *adequate shelter*.

The committee had no problems concerning military affairs during the year.

/s/ George W. Paschal, Jr., M.D.
Chairman

COMMITTEE ON SCIENTIFIC EXHIBITS

This Committee reports the acceptance of thirty-six exhibits for the Annual Meeting this year. Of this number thirteen are from agencies or associated medical agencies of the Medical Society. There were twenty-three scientific exhibits accepted, thirteen of these are of North Carolina origin.

Recommendation is made by this year's committee that a committee meeting be held during the Annual Session each year of the new committee members for the purpose of making plans regarding subject matter and composition of the following year's exhibit program. It would improve the liaison with the other program committees for the annual meeting if some correlation could be worked out to include chairmen of these committees for the purpose of long range planning and improving this medium of post-graduate education. It has been felt that our Society Meetings become somewhat compartmented and need closer liaison to improve presentation and increase Society interest.

/s/ Ralph W. Coonrad, M.D.
Chairman

COMMITTEE ON EYE CARE AND EYE BANK

The Eye Bank needs and services have been emphasized throughout the year. Efforts have been made to obtain greater interest and participation in the Eye Bank from all members of the Medical Society. All speeches before civic clubs have afforded a good opportunity to pass on this information.

The Eye Care Committee has cooperated with the Committees from specialty societies in recommending vision screening for school children. A definite outline of this program should be available at an early date.

Discussions have been held concerning billing procedures for indigent patients, paid for by state and local government agencies. Recommendations were submitted to the Eye Surgeons in the State.

Participation by the Committee in the relative value fee schedule has been effective and the eye sections fees have been decided upon and are to be presented for approval to the House of Delegates.

/s/ George T. Noel, M.D.
Chairman

COMMITTEE ON FINANCE

Parkinson's Law: "The Deliberations of any Finance Committee will be in inverse proportion to the sum involved".

The financial report ending Dec. 31, 1959 shows a healthy surplus of income over expenditures.

Sixty-seven per cent of this surplus was due to the activities of headquarters office in selling national and local advertisement. The biggest item in the budget still remains the Journal, accounting for 33% of the total budget. Headquarters activities were next with 24% of the total. All the remaining departments range from 6% to 11%.

You will note that the total expense of the Journal was \$60,308, while the income from advertisement amounts to \$60,973 or a profit of \$665.00. This is somewhat misleading in that the headquarters office does most of the selling of the advertisement, and the expense to this office is not shown in the Journal budget.

You can also see that the expense of the annual convention is met by the income from the exhibits and sale of banquet tickets. But here again the effort of our headquarters personnel is not shown in these figures.

The Finance Committee in cooperation with the Publications Committee and Headquarters Office is making every effort to make the Journal and annual convention self supporting, and I believe it will be done.

All surplus funds have now been invested in an open end Mutual Fund of stocks and bonds, and a better return on investments is expected in the future. Prior to 1959 our surpluses were invested in government bonds.

Our real estate investment on the Raleigh Durham Highway continues to be good, and it can be liquidated any time the need should arise at a profit.

Headquarters office continues to be run efficiently and effectively. There was no apparent friction or dissatisfaction among the personnel. So, all in all, 1959 looks rosy, and may 1960 do as well.

/s/ Wayne J. Benton, M.D.
Chairman

COMMITTEE ON MEDICAL GOLF TOURNAMENT

The Medical Society State of North Carolina annual golf tournament will be held at the Raleigh Country Club on Monday and Tuesday, May 9th and 10th 1960. The tournament will be a low gross, low net tournament with handicaps based on the Calloway system. The player must register and post his first 18 hole score as his official score.

The player with low gross score will be awarded the rotating golf trophy to be kept until the next tournament. A low gross prize and low net prizes will be awarded.

We should like to request expenditures up to \$200. A portion of such an allotment would be spent to pay an attendant to manage the tournament for two days, to post all scores, to keep current a master tournament board, and to render a final report at the end of the tournament. We have in mind a professional golfer for this service. If such an expense is not incurred the

budget would then fall below the allotted amount.

/s/ Charles W. Styron, M.D.
Chairman

COMMITTEE ON MEDICAL SOCIETY HEADQUARTER'S FACILITIES

The Committee is glad to report that through Mr. Barnes' effort and cooperation with the committee, additional facilities were secured for the Medical Society Headquarters on the second floor of the Capital Club Building in Raleigh. These facilities are adequate to meet our needs for an indefinite time.

/s/ Lenox D. Baker, M.D.
Chairman

COMMITTEE ON HOSPITAL AND PROFESSIONAL RELATIONS AND LIAISON

NORTH CAROLINA HOSPITAL ASSOCIATION

The Committee on Hospital and Professional Relations met at the Carolina Hotel, Pinehurst, North Carolina, September 25, 1959.

ITEM I

The origin and past experiences of this Committee were reviewed by the Chairman. The situation and experience relating to the Davie County Memorial Hospital, Mocksville, N. C., was reviewed and there was reported that all problems relating to professional and hospital administrative personnel were resolved and that the spirit prevailing in that community was one of mutual respect and cooperation.

ITEM II

Certain problems arising out of the present North Carolina survey of hospitalizations under the standardization program of the Joint Commission of Accreditation of hospitals was discussed. It was considered by this Committee that stop orders on drugs should be left to the autonomy of particular hospitals and it was felt that the Joint Commission on Accreditation failed to consider sufficiently the local situation of hospitals in holding to their recommendations. It was the feeling of this Committee that recommendations for stop orders on dangerous drugs would not be frowned upon by the vast majority of physicians practicing within the confines of the State Society of North Carolina. The above data was received by this Committee in the form of a Resolution submitted by the Mecklenburg County Society, and it also encompassed the thought that it should be ascertained as to what exactly the Joint Commission was trying to do. It was wondered whether they were trying to develop a set of standards applicable to all hospitals, or whether they were attempting to set up a set of standards which will ultimately infringe upon the practitioner's treatment of his patient. A motion was made and duly seconded to accept the above Resolution as information without action.

ITEM III

The County Society Survey relative to methods of providing medical services to needy patients

was discussed. Due to the fact that too few surveys had been returned for adequate evaluation it was decided that no action or recommendations be made until more reports were received. The Committee next considered the Placement Service of the Headquarters Office and it was decided that this Service should undertake to determine facts in placement of physicians as staff private practitioners where current practitioners had declined or have desisted from staff organizations where new community hospital facilities have been authorized and are under construction. It was felt that the Placement Service should undertake to determine all facts in such situations before undertaking placement in areas of possible conflict of interest before pursuing placement efforts, possibly referring the matter to this Committee for investigation.

ITEM IV

The Gaston County Medical Society correspondence in reference to a physician administering his own medications in the emergency room, to emergency room outpatients, was reviewed. The Administrator of the Gaston Memorial Hospital informed this Committee that the ruling by the Hospital Administration that "No doctor can give his own medication to an outpatient and that all drugs given in the emergency room must be only administered by hospital personnel" was in full force and acceptable to the Medical Staff.

ITEM V

On July 15th, 1959, the following announcement to the medical profession in the Murphy, North Carolina area was circulated by the Board of Trustees of the Murphy Protestant Hospital: "At a meeting of the Board of Directors of the Murphy Protestant Hospital, Inc., July 10, 1959, it was resolved by the Board of Directors that the Administrator notify all doctors that the hospital now maintains and operates all x-rays and laboratory facilities and be made available to all doctors when requested and all work to be done by the hospital technician. It was further resolved by the Board of Directors that all the doctors in Cherokee County and surrounding counties be advised that the Murphy Protestant Hospital, Inc., was now operating complete facilities and all outpatients referred to said hospital for x-ray work would be given prompt attention and that usual and customary charges be made to the patient for such service and that the hospital would split or divide for such services when collected on the basis of two-thirds of amount collected to the hospital, and one-third to referring physician. The above Resolution was unanimously adopted by the Board of Directors upon motion made and seconded. Signed: Mrs. Warner Nona Rowland, Secretary." The above announcement was brought to the attention of this Committee by way of the State Medical Society by Dr. Bryan W. Whitfield, Murphy, N. C. A member of this Committee, Dr. J. S. Raper, in December 1959, discussed this situation with Dr.

Whitfield and Dr. Helen Wells of Murphy, N. C., and was assured that insofar as they knew no division of fees by the hospital and referring physicians had taken place. It was the feeling of Dr. Raper that without further action on the part of the hospital in Murphy, and of the original complainant, that no further action was required by this Committee.

ITEM VI

On October 6, 1959, the Chairman of this Committee was contacted by the President of the Stanly Medical Society concerning a very basic problem which had arisen in the Stanly County Hospital concerning the admission or rejection of an applicant to the active staff of the above named hospital by the Board of Trustees of the Stanly County Hospital over the objections of the majority of the Professional Staff. On October 15th and October 25th, 1959, Doctor's Lee Large, Jr., Paul Deaton, John Reece, William Fowler, Jack Wilkerson, and Theo H. Mees, Chairman of this Committee, held two rather prolonged meetings in the Stanly County Hospital in Albemarle, N. C. The above members of this Committee met with the hospital Administrator, the Board of Trustees, the Professional Staff of the Stanly County Hospital, and the many members of the Stanly County Medical Society. After a rather lengthy investigation and due discussion of the problem presented to us it was the opinion of this Committee that several problems existed in the Stanly County Hospital. These were: (1) The probability of the Board of Trustees of the Stanly County Hospital over-riding the wishes of the majority of the Staff concerning the admission to the active Staff of the Stanly County Hospital of a certain physician, licensed in the State of North Carolina. (2) The lack of proper liaison between hospital Staff and Board of Trustees. (3) The lack of faith and trust is demonstrated between administrative and professional groups concerned with the operation of the above named hospital.

After due deliberation and discussion by this Committee with the members of the Staff, Stanly County Medical Society, Hospital Administrator, and Hospital Board of Trustees, it was the opinion of this Committee that the Medical Staff acted in good faith and without prejudice in reaching the decision concerning the rejection of the application of the physician in question. It was the consensus of this Committee that it recommended to the Board of Trustees that they accept the action of the Professional Staff at face value and accept their report. It was the feeling of this Committee that if the Board of Trustees confirmed this physician's appointment to the active staff over the recommendations of the staff of the hospital, the hospital staff would be placed in an untenable position and the breach between staff and Trustees would be broadened. It was further the opinion of this Committee that the Professional Staff and administration might take

under advisement ways and means of improving communications between the various facets of the hospital organization to improve liaison channels. This should include attendance by the Administrator at hospital staff meeting, hospital executive committee meetings, and the pertinent hospital Staff Committee Meetings. Through occasional combined meetings of the executive committees of hospital staff and administrative board could serve as avenues of communication for evaluation of the hospital status. In the opinion of the hospital and professional relations committee such means of freedom of expression between the groups could serve to effect a better understanding in mutual appraisal of the problem existing in a hospital organization and further promote and enhance the feeling of mutual respect and good faith between all parties sincerely interested in a sound hospital organization.

All responsible interested parties were sent a report of this Committee. The Board of Trustees of the Stanly County Hospital promptly met and appointed the physician in question to the active staff of the hospital despite the objections of the majority of the members of the Professional Staff of the Stanly County Hospital. As a result of the action taken by the Board of Trustees at the Stanly County Hospital, certain facts were pointed out to them. The hospital Board of Trustees was referred to Bulletin No. 19, dated December 1958, of the bulletin of the Joint Commission on Accreditation of hospitals to the effect that the governing body has a moral obligation to appoint only those physicians who are judged by their fellows to be worthy of good character, and qualified and competent in their respective fields. It was also pointed out to them the report of the Joint Commission of Hospital Physician Relations of the Board of Trustees of the American Medical Association and American Hospital Association, dated June 1953, which reads as follows: "It would seem unnecessary to state that in a learned and highly technical profession true qualifications of a member can only be judged by the members of the same profession." "It is a basic principle that hospital governing boards and administrators should not attempt to tell physicians how to practice medicine but rather see that the hospital medical staff organizes to provide a framework for staff self-government." It was also noted in the same report that "lack of understanding and appreciation of these important relationships have caused much criticism and irritation between members of the hospital governing board and medical staff and the Administrator."

On January 26, 1960, information was received by the Chairman of this Committee that the physician in question had closed his office in Albemarle and has moved West. There is still, at present, much conflict between staff and Trustees and indeed amongst members of the Stanly County Medical Society, themselves. It is sincere-

ly hoped by members of this Committee that these conflicts amongst the professional group will resolve themselves very quickly and the endeavors and the intentions of the Medical Profession in Stanly County be directed towards giving the best possible medical care to the citizens of Stanly County.

ITEM VII

The last problem which has confronted this Committee was a problem held over from this Committee the preceding year. It involved a member of this Medical Society appealing for help in regaining certain types of operating privileges being denied him in the hospitals in the city of his residence. This problem resolved itself due to the death of the physician in question.

During the year 1960 no meeting between the members of this Committee and the members of the Liaison Committee from the North Carolina Hospital Association was held.

/s/ Theo. H. Mees, M.D.
Chairman

COMMITTEE TO WORK WITH NORTH CAROLINA INDUSTRIAL COMMISSION

The Committee to work with the North Carolina Industrial Commission has continued its work in much the same vein during the past year as it has previously. We have made several steps forward during the past year and have failed in several others.

The base fee of physicians for office calls after the second visit and for hospital care each day has been increased from \$2.50 to \$3.00 effective January 1st, 1960. An additional recommendation that a time limit be added to the flat rate set down by the Industrial Commission was not approved by them.

A rating guide for the spine and extremities which was submitted by a group from the North Carolina Orthopaedic Association to the section of the North Carolina Medical Society on Orthopaedics and Traumatology has been presented to the Commission. They have approved. They do not have any appropriate publication forthcoming in which this can reach the doctors. The State Medical Society is going to publish this in booklet form this spring. The Industrial Commission has agreed to incorporate this in the next publication of their booklet on medical, dental, nursing, and hospital fees.

It has been recommended by the Section on Orthopaedics and Traumatology that the Industrial Compensation Act be amended to change the relative values of various portions of the extremities. This is to be submitted to the 1961 Assembly. The physicians of the State will be circularized at the onset of the 1961 Assembly and it is hoped that grass root support for this measure will result in its early passage.

It has been noted that recently there has been an increase in the percentage of reduction of physicians' fees excluding those for flat rates. There has also been an almost proportionate increase

in the number of flat rate charges which are submitted not in keeping with the fee schedule.

The Medical Society has been circularized about the new procedures of the physicians billing on industrial cases which are also involved in third party tort-feasor action. This Legislation was sponsored by this Committee. A member of this Committee, Dr. Guy Odom, is going to speak on the General Practice Section of the next North Carolina Medical Society meeting on some of the basic principles of the Workman's Compensation Act.

The North Carolina Industrial Commission has been cooperative in furnishing the Medical Advisory Committee with abstracts of cases with contested fees. This has been a great help to the Committee in rendering intelligent opinions.

Our work with the Industrial Commission has continued to be pleasant, close, and we feel, mutually beneficial.

/s/ Thomas B. Dameron, Jr., M.D.
Chairman

COMMITTEE ON INSURANCES

The Committee on Insurances was fairly active during the current year with three meetings being held and much being accomplished. The first meeting was held July 30 in Wilmington, N. C., at which time the professional liability program was reviewed and a request made to the St. Paul Company for a meeting with company representatives in Raleigh on September 15. Also at this meeting, discussion was entered into concerning a life insurance plan for the members of the State Society. The recommendation on this was deferred until a later meeting scheduled September 25.

Mr. J. L. Crumpton appeared before the insurance committee July 30 and proposed a plan which was more liberal than the plan presently being written for the members of the Society in regard to disability. The Committee recommended approval by the Executive Council at its meeting in September.

Mr. Ralph Golden reviewed the experience with the group professional overhead program and the catastrophic hospitalization program both of which were progressing satisfactorily and the Committee recommended that these receive continued endorsement.

A meeting was held in Raleigh, September 15, with Dr. John Reece, Mr. James T. Barnes, Mr. John Anderson, Mr. Don Clifford of the St. Paul Company, and Dr. J. W. Hooper present. At this meeting the St. Paul Company recommended in effect a 10 per cent rate reduction across the board on all types of liability insurance being written by the St. Paul Companies and endorsed by the Medical Society of the State of North Carolina. This was tentatively accepted and a recommendation made to the insurance committee to recommend executive committee acceptance of the proposal.

The Committee on Insurances met in Pinehurst

on September 25, 1959, at which time a report of the September 15 meeting in Raleigh was made by the Chairman. The Committee recommended to the Executive Council that the proposal of the St. Paul Company be accepted.

At this meeting, it was the feeling of the Insurance Committee that a recommendation should be made to the Executive Council that the Medical Society of the State of North Carolina not endorse any type of life insurance program.

Also at this meeting it was re-affirmed that Mr. Crumpton's proposal on disability insurance be endorsed and passed on to the Executive Committee.

The membership of the Society was to be acquainted with the advantages offered by Mr. Crumpton's company as regards disability by literature sent out by Mr. Crumpton's office. It was also agreed that the members of the State Society would be acquainted with the decreased rates offered by the St. Paul Company by literature mailed out by the St. Paul Company over the signature of the Chairman of the Committee on Insurances.

Since the last meeting of the Committee on Insurances, September 25, a further rate deduction has been obtained by the St. Paul Companies in view of a reduction in the bureau rate for physicians and general practitioners in the State. The information on this rate reduction will again be passed on to the membership of the Medical Society through letters from the home office of the St. Paul Insurance Companies.

It is the feeling of the Committee on Insurances that the liability program endorsed and supported by the Medical Society of the State of North Carolina and administered by the St. Paul Companies is the best type of liability insurance available to the membership at this time. The committee wishes again to emphasize that it is not in the insurance business but acts merely in an advisory capacity to members of the Society. Since inception of this program in 1956, three rate reductions have been obtained and there is every expectation if the experience continues as it has in the past that further reductions can be obtained in the future. This will depend on wider support by members of the Medical Society of the State of North Carolina.

The Committee also wishes to emphasize to the membership that no claims are settled by the St. Paul Companies prior to thorough investigation by the Committee on Insurances through specialty type panels set up in the areas involved throughout the state. Also no member of the Medical Society of the State of North Carolina has been denied professional liability insurance without thorough investigation by the Committee on Insurances. Professional liability insurance has only been denied with consent of the Committee on Insurance.

/s/ Joseph W. Hooper, M.D.,
Chairman

COMMITTEE ON LEGISLATION

Submitted herewith is a report of the activities of the Legislative Committee for the year just concluded. Since this year did not include an N. C. State Legislature, the activities of the Committee were considerably reduced.

However, efforts of the Committee were aimed at improving the opposition to the Forand legislation nationally.

The Chairman of the Legislative Committee attended the Conference of the American Medical Association in St. Louis to discuss opposition of the Forand legislation.

Recommendations have been received for future legislative consideration.

And finally, the Committee reports progress.

/s/ Hubert McN. Poteat, Jr., M.D.
Chairman

COMMITTEE ON MATERNAL HEALTH

The total number of livebirths in North Carolina reached a high point in 1956 (table I). The number of livebirths then fell to its lowest level since 1951 in the year 1958. A slight rise was noted again in 1959, and it is anticipated that this rise in total births will continue. The rise in the total number of births cannot be attributed to marked increase in the birth rate, rather to an increase in the population which has been advancing steadily for some years. The birth rate has been dropping since 1954. The demographers have predicted there will be a steady increase in the number of livebirths throughout the United States. However, they have reduced their previous estimates and the North Carolina experience certainly justifies this. Although we can expect a continued increase in the number of livebirths during the next decade, it certainly will not be of the order previously predicted. Accurate population figures for the state are not yet available and predictions for the future will become more realistic when these figures are available after the 1960 census.

In the past few years there has been a rise in the perinatal mortality rates as well as infant mortality rates. This has caused considerable concern among obstetricians, pediatricians and others interested in the problem. This rise has been noted in North Carolina (table II). The review of the four basic mortality rates reveals that the maternal mortality rate has gratifyingly continued its steady fall. This reduction in the maternal mortality rate may be attributed to numerous factors such as improved prenatal care, an increasing percentage of deliveries in hospitals, blood banks, antibiotics, improved obstetric techniques, and the activities of committees such as this. Perinatal mortality, on the other hand, has shown an increase in the past two years. Perinatal mortality is considered to be a more sensitive index of obstetric care than maternal mortality. Examination of the two components of maternal mortality, namely fetal and neonatal mortality, reveals the fetal mortality

has dropped since 1950 but in recent years the drop has been very slow. On the other hand, there has been a rise in the neonatal mortality rates in the last two years. Throughout the United States this increase in neonatal mortality has been present since 1956. The causes for this are not clear. A study conducted by the National Office of Vital Statistics indicates that the increase in the neonatal mortality throughout the country is due to an increase in deaths due to respiratory conditions such as asphyxia, atelectasis, pneumonia of the newborn, etc. In general, it is felt that most of these deaths are due to acquired disease in the early neonatal period. At the present time it is not clear whether any obstetric factors are responsible for this increase in neonatal mortality. It should be noted that there is also an increase in the postneonatal deaths, or those deaths which occur after 28 days of life. This again would indicate that perhaps the increase is due to factors other than obstetric.

The increasing number of deliveries which occur in hospitals has been one factor responsible for the continued reduction of maternal deaths throughout the United States. The increase in the number of hospital deliveries in North Carolina has been remarkable (table III). In 1950 only 70 per cent of the total resident livebirths in North Carolina occurred in hospitals. This same year 17 per cent of the deliveries were performed by a physician at home, the remaining 13 per cent by midwives. By 1958, 88.5 per cent of all resident livebirths occurred in a hospital. Four point 4 per cent occurred at home attended by a physician and 7.1 per cent occurred at home attended by a midwife. During this period of time the two most striking features were the reduction in the number of deliveries at home attended by a physician. This can be ascribed to the excellent network of hospitals throughout the state provided by the individual communities with the assistance of the Hospital Care Commission. There has also been a marked change in the attendant and place of delivery for the nonwhite group in particular. In 1950 only 38 per cent of the nonwhite group were delivered in hospitals. This has risen to 68 per cent by 1958. The figures for 1959 are not available as yet. The increase in the number of deliveries under the supervision of physicians and in the hospital is considered by the Committee as desirable and it is our belief that it will continue.

Year by year the primary causes of maternal mortality in North Carolina continue to be dominated by toxemia and hemorrhage (table IV). The total number of maternal deaths is dropping steadily as is the maternal mortality rate as seen in table II. Since most of the causes listed in table IV are preventable, maternal mortality rate in North Carolina is a long way from the so-called irreducible minimum. Many years ago most obstetricians were stating that maternal mortality had reached an irreducible

minimum. However, as more attention was paid to the actual causes of maternal deaths and less to the rates, it became apparent that we had not yet reached our goal of the irreducible minimum. It is encouraging, however, to see a greater number of nonobstetric deaths among those cases reported to the Committee. Furthermore, certain observations can be made only by reading individual case histories. The cause of death as reported on the official death certificates has improved considerably since the Committee began its investigation in August, 1946. The cases as they are worked up and presented to the Committee are considerably more detailed and indicate a better clinical record if not better examination and care for the patient. These points are not well described by the usual set of data. It should also be stated that there has been practically no physician who has been unwilling to cooperate with the Committee in recent years. Practically all the physicians involved have not only been cooperative, but have indicated a definite interest in the opinions of the Committee and very often have provided case reports and autopsies even before the routine questionnaire reaches them.

The primary cases of maternal deaths from the years 1946 through 1959 are shown in table V. Two tables concerning maternal deaths by race are in tables VI and VII.

The Committee held one meeting in 1959, on August 16, at Gastonia, North Carolina. At this meeting a motion was made to suggest to the Executive Council that they consider the desirability of obtaining certain information concerning the physicians who perform deliveries in North Carolina, and to incorporate this information on punch cards. Such items as the physician's race, date of birth, address, medical school, postmedical training, etc. This suggestion was presented to the Executive Council on September 29, 1959. The Executive Council accepted the suggestion and submitted it to the Central Office for further action. The Committee was apprised of the plans of the North Carolina State Medical Society to hold two annual meetings, at which time all the committees of the state organization could meet and conduct their business. The Committee recognized the highly desirable features associated with such meetings, but voted to continue at least one separate meeting of its own primarily for case history presentation. The Committee also passed a motion to recommend to the Executive Council that a secretary be appointed to assist the Chairman of the Committee in carrying out the duties of the Committee. This suggestion was also approved by the Executive Council and on September 28, 1959, Dr. Joseph W. May, of Winston-Salem, was appointed secretary to the chairman. The Committee regrets the announcement of the resignation of Dr. Paul R. Kearns, of Statesville, who is moving to another state.

Material from the files of the Committee on Maternal Welfare was presented on the following dates by Dr. Donnelly:

January 29, 1959, "Induction of Labor," Postgraduate Course of the University of North Carolina, in Goldsboro, N. C.

April 14, 1959, "Diabetes of Pregnancy," at the John A. Andrew Clinical Society, Tuskegee, Alabama.

April 15, 1959, "Maternal Mortality in North Carolina," at the Committee on Maternal Mortality

of Springfield, Massachusetts.

April 16, 1959, "Maternal Mortality," Postgraduate Course in Obstetrics and Gynecology at the Harvard Medical School, Boston, Massachusetts.

October 20, 1959, "Distribution of Deliveries among Physicians in North Carolina," American Public Health Association, Atlantic City, New Jersey.

The financial report for the year 1959 is as follows:

RECEIPTS		DISBURSEMENTS	
Balance, 12-31-58	\$ 131.68	Salary: Secretary	\$2,400.00
Medical Society of North Carolina—check	2,730.00	Social Security Tax	55.00
		Photo Charges	115.00
		Postage	41.00
		Telephone	7.50
		Stationery	25.60
		Maintenance on machines and supplies	109.71
		Office supplies	52.59
		Travel expense—Dr. Eastman	97.37
		Overhead	50.00
		Total expenses	\$2,957.32
	\$2,861.68		2,957.32
Overdraft	95.64		
	2,957.32		\$2,957.32

/s/ James F. Donnelly, M.D.,
Chairman

TABLE I
RESIDENT LIVEBIRTHS AND BIRTH RATE
North Carolina — 1950-1959

Year	Total Livebirths	Birth Rate
1950	106,486	26.2%
1951	110,910	26.9%
1952	111,272	26.7%
1953	111,856	26.5%
1954	114,846	26.9%
1955	115,365	26.7%
1956	116,274	26.5%
1957	113,440	25.6%
1958	110,492	24.7%
1959	111,344*	N.A.

*Provisional

TABLE II
MATERNAL, FETAL, NEONATAL AND POSTNEONATAL MORTALITY RATES
North Carolina — 1950-1959

Year	Maternal	Fetal	Neonatal	Postneonatal
1950	11.8	24.1	21.4	13.1
1951	11.1	23.4	20.6	12.1
1952	10.2	22.1	22.0	13.6
1953	9.7	19.9	20.3	12.4
1954	7.1	20.5	19.4	10.8
1955	8.3	20.5	19.5	10.8
1956	7.0	19.1	20.4	10.5
1957	7.4	18.5	19.9	10.6
1958	5.7	19.8	21.1	11.5
1959*	5.1	19.5	21.7	11.8

*Provisional

Maternal mortality rate based on 10,000 livebirths

Fetal, neonatal and postneonatal rates on 1,000 livebirths

Perinatal mortality may be obtained by adding fetal and neonatal mortality rates.

Infant mortality may be obtained by adding neonatal and postneonatal rates.

TABLE III
PERCENTAGE RESIDENT LIVEBIRTHS BY PLACE OF BIRTH AND ATTENDANT
North Carolina — 1950-1959

Year	Hospital	Physician-Home	Midwife
1950	70.0	17.0	13.0
1951	75.0	13.0	12.0
1952	78.6	10.4	11.0
1953	81.0	8.6	10.4
1954	83.0	7.0	10.0
1955	85.0	6.0	9.0
1956	86.5	5.1	8.1
1957	88.0	4.3	7.7
1958	88.5	4.4	7.1
1959	N.A.	N.A.	N.A.

TABLE IV
PRIMARY CAUSE OF MATERNAL MORTALITY
North Carolina — 1955-1959

	1955	1956	1957	1958	1959	Total
Toxemia	45	36	30	33	19	163
Hemorrhage	52	38	21	26	29	166
Embolism	16	8	4	3	8	39
Infection	9	12	4	6	8	39
Cardiac	5	4	1	2	6	18
Anesthesia	2	5	3	3	2	15
Other obstetrics	17	19	27	20	20	103
Nonobstetric	25	30	17	21	33	126
Incomplete	3	7	31	16	3	60
Total	174	159	138	130	128	729

TABLE V
PRIMARY CAUSE OF MATERNAL MORTALITY
North Carolina — 1946-1959

	1946-1949		1950-1954		1955-1959	
	#	%	#	%	#	%
Toxemia	213	27.1	270	28.5	163	22.4
Hemorrhage	200	25.4	215	22.7	163	22.8
Embolism	62	7.9	81	8.5	39	5.3
Infection	60	7.6	55	5.8	39	5.3
Cardiac	34	4.2	29	3.1	18	2.5
Anesthesia	22	2.8	25	2.6	15	2.1
Other Obstetric	72	9.2	89	9.4	103	14.1
Nonobstetric	89	11.3	147	15.5	126	17.3
Incomplete	35	4.5	35	3.7	60	8.2
Total	787	100.0	946	99.7	729	100.0

TABLE VI
MATERNAL DEATHS BY RACE
North Carolina — 1955-1959

	1955	1956	1957	1958	1959	Total
White	56	51	48	37	49	241
Nonwhite	118	108	90	93	79	488
Total	174	159	138	130	128	729

TABLE VII
MATERNAL DEATHS BY RACE
North Carolina—1946-1959

	1946-1949		1950-1954		1955-1959	
	#	%	#	%	#	%
White	346	43.9	357	37.7	241	34.0
Nonwhite	441	56.0	589	62.3	488	66.0
Total	787	99.9	946	100.0	729	100.0

MEDICAL—LEGAL COMMITTEE

I. Review of work done to date:

A meeting of the Medical-Legal Committee was held in Pinehurst, N. C., on September 25, 1959, five members being in attendance. Ways and means of stimulating added interest in the joint meeting of the County Medical Societies and the County Bar Associations were discussed. Joint meetings were held in approximately 20 counties during the year.

II. Unethical actions:

No incidents of alleged unethical conduct on the part of physicians have been reported to the Committee.

III. New Fields:

It was felt that there would very likely be a lag in interest in joint meetings on the Coun-

ty level following one or two such meetings. Bringing in out-of-County speakers, consolidating adjoining counties in their joint meeting, giving the lawyers opportunities to plan programs, etc., were suggested as measures to stimulate interest.

IV. New Films:

The fifth in a series of six planned films pertaining to medical-legal subjects is now available. This latest one is entitled "A Matter of Fact," and is of 30-minutes length.

V. Recommendations for future:

- A. Promotion of further joint meetings.
- B. Consideration of a trial of the "Expert Medical Testimony Plan" in one of the larger cities in North Carolina.
- C. Promotion of study course in medical-legal subjects to be sponsored by Legal

Department of American Medical Association.

D. Reprint of Code.

/s/ Julius A. Howell, M.D.
Chairman

COMMITTEE ON MENTAL HEALTH

The Medical Society's Committee on Mental Health held a meeting in Pinehurst, N. C., September 26, 1959 during the Committee Conclave. Ten members were present in addition to two guests.

Guided by a prepared agenda, the committee discussed the following items and made recommendations for follow-up work.

1. Governor's Council on Mental Health: The Chairman reported on a meeting of this Council, September 18, 1959. Attention was called to the need for more psychiatric training for general practitioners. A motion was made to invite Dr. Ernest Ferguson, a member of the Academy of General Practice Committee on Mental Health, to appear before the next full committee meeting and report on progress being made to date and that proposed for general practitioners.
2. Announcement was made as to the 1960 annual Congress on Occupational Health being held in Charlotte, N. C. October 10-12. Mental health will be one of the topics presented and discussed at this annual Congress meeting. Members of the Mental Health Committee are invited and urged to attend the meeting. The State Committee on Occupational Health and the Mecklenburg County Society's Committee are cooperating with the A.M.A. Council in Industrial Health in sponsoring the Congress.
3. In the absence of Mrs. Robert L. Garrard, President of the Medical Auxiliary, Mrs. John C. Reece read a report from Mrs. Garrard and expressed the Auxiliary's interest in mental health. The Auxiliary is proposing the establishment of a mental hospital bed at the University of North Carolina Hospital. Fund to be established for Research and Education in Mental Health. This project to be similar to the Yoder Beds for tuberculosis patients, a long term project of the Auxiliary.
4. The Committee went on record as appreciating the Auxiliary's interest and proposed project but recommended that the bed not be limited to utilization by a member of the Medical profession.
5. Major attention was given at the Pinehurst meeting to the problems of operating and staffing our mental health clinics. We now have eleven clinics operating under the State Board of Health. Very few of the clinics have full-time staffs. A motion was made and seconded, that a Committee be appointed to investigate further the proposition of shifting control of Mental Health Clinics from the State Board of Health to the N. C. Hospital Board of Control. This recommendation was presented

to the Executive Council on September 27th. 6. In discussing the unsuccessful attempts in getting the proposed legislative Crime against Nature Bill before the 1959 General Assembly, two alternate courses of action were suggested:

- a. Through Mr. Umstead try and get law passed requiring Governor to appoint a Study Commission to explore, review, and report on the problem and to propose a bill to the next General Assembly.
 - b. Find a sponsor for the present bill and submit to the next General Assembly. A subcommittee of the State Mental Health Committee worked hard in doing the necessary research and in preparing a Bill in early 1959. The same subcommittee was requested to continue its activities in behalf of having this legislation passed.
7. The one rehabilitation assignment given the Committee in 1958-59 was reported as having been proved successful. The individual in question has been under proper treatment and guidance and has returned to gainful employment, showing competence, self-discipline and integrity, and has expressed his sincere appreciation to this Committee for its efforts in his behalf.

As Chairman of the Committee, I wish to take this opportunity to express appreciation and thanks to the members for their cooperation, support, and willingness to serve and work on this committee. Though we have not held frequent meetings, contact has been maintained by the Chairman with members when questions arose or action was needed and requested.

/s/ Allyn B. Choate, M.D.
Chairman

COMMITTEE ON MEDICAL CARE ARMED FORCES DEPENDENTS— ("MEDICARE")

At the Annual Meeting of the House of Delegates May 4, 1959, the Chairman of the Medicare Committee was instructed to re-negotiate the Medicare Contract, seeking the best terms available. This was done and the contract was essentially the same as before, operating under the restrictions placed on the program as of October 1, 1958. On this limited and unsatisfactory basis, both to the doctors and the dependents, the program has been carried out in North Carolina in spite of the confusion of the cutback. However, the restrictions were lifted as of January 1, 1960, for elective surgery for those residing apart from their sponsors due to the exigencies of the service. The increase in the number of claims that were caused by lifting restrictions on those residing apart from their sponsors has not been as great as was anticipated. I think the lack of increase in number of claims is due to the situation of spouses and dependents of members of the uniformed services not being properly informed of the increase in the scope of the program as of January 1.

The Committee has had three full meetings, and the Chairman has conferred frequently with Mr. James T. Barnes and Mr. K. G. Beeston. In addition, the Obstetrics & Gynecology Subcommittee under Dr. J. C. Burwell, Jr., has had separate meetings. A record of the minutes of each of the three meetings is on file in the Headquarters Office of the Medical Society.

We are pleased to report that Hospital Saving Association has given us excellent administration, and Mr. E. B. Crawford and Mr. K. G. Beeston have been very conscientious in carrying out the decisions of the Committee and policies established by the State Medical Society. The report from Hospital Saving Association is attached as *Exhibit I*.

The Committee wishes to express their gratitude to Mr. James T. Barnes, Executive Director of the State Medical Society, who has given generously of his time and talents to the Committee. Mr. Barnes' untiring efforts, including insight as to what is best for the North Carolina Medical Society makes him an invaluable asset to the Committee Chairman. The Chairman also wishes to express appreciation to all members of the parent committee and sub-committees for their complete cooperation and help during the past fiscal year.

Committee Recommendation to The House of Delegates

	1957	1958	1959
Number of claims paid	12,756	18,651	11,905
Amount paid	\$1,012,738.65	\$1,498,422.05	\$1,057,569.80
Average Payment per claim	\$79.39	\$80.34	\$88.83

Under a separate contract, the Association is authorized to reimburse hospitals for care provided military dependents eligible to receive

	1957	1958	1959
Amount paid	\$663,997.77	\$1,091,254.76	\$831,016.93
Average hospital payment per case	\$78.67	\$87.55	\$96.64
Average hospital payment per day	\$14.98	\$16.51	\$16.89
Average stay	5.3	5.3	5.7
Cases	8,440	12,465	8,599
Days	44,331	66,083	49,198

The hospital payment figures do not include the patient payment to the hospital of the first \$25 or \$1.75 per day, whichever is greater.

Effective January 1, 1960, the Medicare Program was restored to essentially the same benefits as originally provided by the Program. Dependents residing with the servicemen are still required to use military facilities or obtain a Medicare permit for civilian care if they desire services at Government expense.

The restored Program is expected to increase the claim volume approximately 25% over the

It is the Committee's opinion that the Medicare Program will reach a more stable financial position within allocated funds during the next few months since some of the restrictions have been lifted for services for those living apart from their sponsor. The Committee recommends to the House of Delegates that the Society continue to contract with the Government in the operation of the Medicare program with specific directions to the Executive Council to continue, revise, or discontinue the program as they see fit according to future developments, within the structure of the Directive of the Secretary of Defense and the regulations promulgated thereunder by the Office of Dependents Medical Care.

/s/ David M. Cogdell, M.D.
Chairman

Exhibit I MEDICARE REPORT TO THE MEDICARE COMMITTEE OF THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA

Period—January 1, 1959 through December 31, 1959

The Association has completed its third year as fiscal agent for the State Medical Society under a contract to reimburse physicians for civilian medical care provided to dependent wives and children of active duty servicemen. Comparative statistics for the three year period of 1957 through 1959 are as follows:

	1957	1958	1959
Number of claims paid	12,756	18,651	11,905
Amount paid	\$1,012,738.65	\$1,498,422.05	\$1,057,569.80
Average Payment per claim	\$79.39	\$80.34	\$88.83

Medicare benefits. Comparative statistics for the three year period 1957 through 1959 are as follows:

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Average stay	5.3	5.3	5.7
Cases	8,440	12,465	8,599
Days	44,331	66,083	49,198

next year. However the claims volume can be effectively regulated by the military by the number of Medicare permits that are issued to dependents residing with their sponsors.

Permits have been issued at Fort Bragg to dependents residing off the military reservation; while at Camp Lejeune permits were issued to dependents residing outside the county in which the installation is located. Small military installations that have no medical facilities continue to issue permits for civilian medical care.

Bulletins have been printed and mailed to all

members of the Medical Society announcing various changes in the Program. Bulletins and announcements as authorized and specified by your committee have been printed and mailed to all members of the Medical Society.

Approximately 25-30 cases per month involving unusual or complex services not covered by the Fee Schedule or services requiring a professional decision by the Medical Society has been referred to the Medicare Committee.

During the past year and from the beginning of the Program the Medicare Committee has contributed greatly of their time and professional knowledge to work on behalf of the Medical Society members and to aid in the administration of this Program. The Medicare Committee and the Medical Society have continued to work for a fair and equitable Program to reimburse physicians for civilian medical care provided military dependents.

We wish to take this opportunity to express our sincere appreciation and gratitude for the continued very excellent assistance and cooperation of the Medicare Committee, its Chairman, its Sub-Committee, and Mr. James T. Barnes' office in the administration of the Medicare Program. March 1, 1960

/s/ K. G. Beeston, Administrative Assistant

/s/ E. B. Crawford, Executive Vice-President

COMMITTEE ON NEGOTIATIONS

Members are Dr. Amos Johnson, Garland, Dr. Theodore S. Raiford, Asheville, Dr. William F. Hollister, Pinchurst.

The work of the Committee on Negotiations during the period of May 1959 to May 1960 has dealt mainly with the problems related to the removal of professional services from Blue Cross certificates and the placement of these professional services in Blue Shield certificates. It is also our purpose to secure this change so that it will affect all types of commercial hospital and professional insurance. The Committee hopes to secure this change through a ruling by the State Insurance Commissioner. To accomplish these changes, the Committee has been working with the North Carolina Society of Radiologists, the North Carolina Society of Anesthesiologists, and the North Carolina Society of Pathologists. Detailed work on the preparation of the brief to be presented to the State Insurance Commissioner is being prepared by Dr. I. Beverly Lake, Attorney, of Raleigh, North Carolina. Meetings have been held with the above mentioned organizations and Dr. Lake for the purpose of integrating the proper thinking in the preparation of the brief.

Problems relating to Third Party encroachment in medical practice which had come to the attention of the Committee have thus far been dealt with in an apparently satisfactory fashion with most parties involved. There are, however, still many areas to be dealt with, and the Committee on Negotiations will continue its services

in attempting satisfactory solutions to these problems.

/s/ Wm. F. Hollister, M.D.
Chairman

COMMITTEE OF PHYSICIANS ON NURSING

The Physician's Committee on Nursing of the Medical Society of the State of North Carolina has continued its sincere and diligent attention to those aspects of nursing which affect the medical profession.

The Committee has worked jointly with the North Carolina State Nurses' Association and the North Carolina Hospital Association, as well as independently, on the subject of past nursing legislation which was submitted to the 1959 session of the State Legislature as well as new legislation to be submitted to the next legislature. The exact form the legislation for the next session will take has not yet been determined but this Committee will report through channels if our Society's approval or disapproval is required.

We have also expressed interest in following up the North Carolina resolution which passes the House of Delegates of the A.M.A. concerning the participation of physicians on the "Blueprint Test Committee" which determines the questions to be asked on the national nursing licensing examination. This has been discussed with the Executive Council.

Upon instruction of the Committee, the Chairman also presented to the Executive Council a request that a member of the State Board of Nurse Registration and Nurse Education report to the Society at their annual meeting on the current status of Nurse Licensure and Recruitment, believing that our Society should be kept currently informed as to what we can expect in nurse availability for offices, hospitals, and Public Health Departments.

The death of Dr. Moir Martin, a faithful and beloved member of this Committee, stands out in our memories as the most meaningful event of this past year. We have expressed our feelings of sympathy to the family and have advised both the Surry County Medical Society as well as the Executive Council of the State Society of our feelings of great loss and our expressions of sincere appreciation of Dr. Martin's loyal service.

The Chairman particularly wishes to commend the loyalty and interest of the members of this Committee and of the faithfulness of Annette Boutwell in handling many of the clerical details for us.

/s/ Robert R. Cadmus, M.D.
Chairman

COMMITTEE ON OCCUPATIONAL HEALTH

Your committee has been quite active during the past year. Most of the work has been concerned primarily with planning for the A.M.A. Congress on Industrial Health, which will be held in Charlotte, Oct. 10-12, 1960. Dr. John Kester and his Mecklenburg County Committee on Industrial Health have been most cooperative.

The general plan of the program is tailored to be of interest and value to the general practitioner. We are all aware that about 90 per cent of the medical work in Industry is done by the general practitioner and a large portion of that is for small Industries.

The September issue of the North Carolina Medical Journal will feature largely articles that pertain to problems in Industrial Health. At this time we are engaged in securing material which will be submitted for Editorial Board approval.

At the present time material is being assembled and edited for a handbook on Occupational Health. Dr. L. W. Wilson, Chief of the Division of Industrial Health of the North Carolina Department of Public Health is editing the material. Dr. Wilson is a valuable asset to the Industrial Health program. He has been most helpful and cooperative.

The annual Symposium on Occupational Health sponsored by the Medical School of the University and your Committee, was omitted this year due to the meeting in Charlotte Oct. 10-12.

/s/ Harry L. Johnson, M.D.
Chairman

COMMITTEE ON POSTGRADUATE MEDICAL STUDY

The Committee on Postgraduate Medical Study met in the Cocktail Lounge in the CAROLINA in Pinehurst, N. C., Saturday, September 26, 1959, at 7:00 P.M. with the following present: Samuel L. Parker, Jr., M.D., Chairman, William P. Richardson, M.D., W. Otis Duck, M.D., Frank R. Reynolds, M.D., and George W. Paschal, M.D., Chairman, PROFESSIONAL SERVICE COMMISSION.

Dr. Parker announced that eleven North Carolina students won the National Foundations' 1959 Health Scholarships. The scholarships were awarded nationally to outstanding young Americans seeking careers in one of five health fields—medicine, nursing, physical therapy, occupational therapy, and medical social work. Each scholarship is for \$2,000 for a total of four years of college training. There were three in medicine, three in nursing, three in physical therapy and two in social work.

The Committee discussed in detail the many seminars, symposiums and other postgraduate medical meetings that are offered to the profession in the State and also discussed what ways and means they might employ to encourage physicians of the State to attend these meetings. It is brought out that these courses usually draw the same physicians each time.

Dr. Parker and Dr. Richardson had previously discussed the problems of getting larger groups to participate. They stated that the specialists are attending their group and national meetings. A certain number of general practitioners are going to extension courses and other meetings. The non-specialists groups are lacking in opportunity for postgraduate information and training. It

was felt that the committee should devote thought as to how we might reach that group of physicians that never "get away" to anything.

A lengthy discussion was held on some type of television program and time that these programs might be presented in order to reach those physicians who never attend courses and never "get away" to meetings. A proposal was made to put on one pilot project and to make this available to commercial stations to be given at some time when there would be low listening time or after regular programs at night or early morning.

The question was raised as to ideas as to how the listing of the information sheet "What Goes On" could be made more useful. Dr. Duck suggested that the Committee make a list of all medical meetings for a period of time and place this in one monthly issue of the North Carolina Medical Journal, perhaps first of year, and this would allow physicians to select the meetings that they could attend in the months ahead. Dr. Paschal stated that this information could be placed in a very small area—less than one page. The J.A.M.A. carries such listings. This information would offer a means of keeping abreast of what is going on and when it is being offered. The Committee was inclined to limit the listings in the North Carolina Medical Journal to those offered in the State, since the J.A.M.A. carries national meetings and the specialty groups know in advance their meetings.

The Committee did not believe that a Study-Recommendation Committee would offer a means of greater exploration of our needs and ways to effect essential programs.

It was stressed that more funds are needed in order that Dr. Richardson might carry on his program at U.N.C. Dr. Richardson suggested and urged that the members of the Society take advantage of and participate in the postgraduate courses.

The Committee endorsed the Committee Conclave, and Dr. Parker expressed appreciation to Dr. Paschal for his attendance at the Committee meeting.

/s/ Samuel L. Parker, Jr., M.D.
Chairman

COMMITTEE ON POLIOMYELITIS

I have the honor to submit the following report:

1—In April, May and June 1959 follow-up letters were sent to the various Reserve Units of the Armed Forces in North Carolina, endeavoring to make poliomyelitis vaccine administration mandatory for all Reserve personnel in every service. Apparently, this has been done finally in every service except the National Guard.

2—In July 1959, upon request, a "Blueprint for Legislative Action"—a complete resume of our efforts in North Carolina to get the Compulsory Poliomyelitis Vaccination Law passed—was forwarded to representatives of the State Medical Societies in West Virginia and in Virginia.

3—In August a press release was arranged, pointing to poor immunization status of our citizens, urging wide-spread immunization.

4—In September there was a meeting of this Committee in Pinehurst, in which the situation was discussed.

5—In October an effort was made through the Director of the State Department of Public Education to see that the law is being enforced before admission in every school in North Carolina. Dr. Carroll promised his faithful cooperation.

6—In February 1960 this Committee met with representatives of the State Division of the National Congress of Parents and Teachers, and with the State Junior Woman's Clubs, at which time we discussed plans of these two bodies to push poliomyelitis immunization all over the State. Representatives of the State Health Department were present at this meeting, and the Junior Woman's Club and Parent-Teacher Association were assured of the cooperation of the State Health Department and of the State Medical Society in their efforts. No flat commitments of Medical Society help were made, but the ladies were assured that in each County where they undertook immunization programs that the County Societies of the Medical Society might be requested to participate, and probably would cooperate.

7—In March 1960 the State Director of Public Welfare was requested to make poliomyelitis immunization a prerequisite to admission to any day-care nursery in North Carolina.

I consider it my duty to point out, as I have done for the past two years to the President of the State Society, that our citizens are sadly lacking in immunization against not only (1) poliomyelitis but also particularly—in the case of most adults and practically all negroes—against (2) diphtheria and (3) tetanus. It is my considered opinion that there should be a committee of the State Medical Society on Immunization in general; not only against poliomyelitis but against the other infectious diseases, but particularly diphtheria and tetanus.

In this State, as in most of the States of our Country, adult citizens truly constitute the neglected age of men. They will never be adequately immunized against infectious diseases until every practicing physician makes it his duty to protect his adult patients against these unnecessary hazards. This will never be done until the individual physician has been educated to this need. To my mind, this is the responsibility of the State Medical Society.

/s/ S. F. Ravenel, M.D., Chairman
Committee on Poliomyelitis

COMMITTEE ON PUBLIC RELATIONS

Again this year, the major effort of the Committee was the sponsoring of a Conference of County Medical Society Officers and Committeemen, held in Pinehurst on January 29, 1960. This

was the second such Conference and represented an effort to assist in the orientation of newly elected County Medical Society Officials, to acquaint them with their duties and responsibilities, and to make them aware of the many avenues of cooperation and assistance open to them through the State Medical Society. Although inclement weather and near-epidemic influenza throughout the state undoubtedly curtailed the attendance, it is still felt that the Conference was sufficiently well received and attended to warrant the sponsorship of such a program again and the Committee does so recommend approval of such a Conference in January, 1961.

In the interest of continuing its efforts to promote mutual understanding between the medical profession and representatives of the information media, a reference list of medical spokesmen was distributed by the Committee to all newspaper editors in the state. Every physician so listed as a medical spokesman was notified that the newspaper serving his area had been supplied with his name. We have received several appreciative expressions from the newspapers for their having been supplied with this list of designated and qualified spokesmen.

An exhibit in the name of the State Society was again sponsored at the North Carolina State Fair, October 13-17, 1959, in Raleigh, using as educational content a graphic comparison of the national dollar cost total for pleasure items versus the total health care cost. The exhibit booth also offered an opportunity for visitors to have their blood typed and to receive an identification card recording this information. Educational literature was distributed at the fair booth and included first aid charts, personal health information cards, family health record booklets and a pamphlet entitled "What Everyone Should Know About Doctors".

One-year complimentary subscriptions to *Today's Health* have been sent to the Governor, Council of State, Supreme and Superior Court Judges, members of the General Assembly, and to U. S. Senators and Congressmen from North Carolina.

Support of the High School Science Fair program has been continued through the North Carolina Academy of Science. Again, this includes a plan to invite one of the High School Science Fair participants in the Biological Science Division to display their exhibit at the Annual Meeting of the State Medical Society. This project is considered a worthwhile undertaking in the direction of stimulating an early interest in the sciences among high school students. Interest in the Science Fair programs at the local level is commended to each County Medical Society as a worthwhile project for consideration.

The distribution of First-Aid Posters continues to be a popular project of the Committee, with requests being received every month for several years from various groups and from individuals

throughout the State for these posters, which are supplied free with the suggestion that the poster be placed inside their home medicine cabinet.

With the hope of stimulating some interest in the socio-economic aspects of medical practice among medical students, copies of the AMA booklet entitled, "The Business Side of Medical Practice" were distributed at the student section meeting at the annual session.

The PR Bulletin has been published nine times during the year, appearing monthly with the exception of May, July, and August. The Bulletin is considered to be an effective means of communicating last-minute information to the membership as well as a means of alerting them to other items of interest to the profession.

More than 50 radio stations in this state have broadcast a transcribed series of programs entitled "Medical Milestones". This series was produced by the AMA and distributed as a cooperative project of the State Society and the AMA.

The Committee Chairman attended the AMA Public Relations Institute conducted by the AMA on August 20-21, 1959 in Chicago. The Institute provides a meeting-place for the helpful exchange of thought, projects, etc., between those interested in medical Public Relations from all over the United States.

The Committee is developing a plan to offer a Press Award to the newspaperman in the state who is judged to produce the best and most factual article about medicine.

The Committee continues its efforts to cooperate with other committees of the Society and to contribute effort to their projects wherever possible.

It is with regret that the Committee announces the recent resignation from the Committee of Dr. Jeff Senter of Raleigh. Dr. Senter, who resigned because of personal reasons, has contributed much to the work of this Committee.

The Committee would like to record its deep gratitude to all the Society officers and the headquarters staff for their encouraging words, forbearance, and assistance as they were related to the mission of this Committee; and especially to Mr. William N. Hilliard, the Executive Assistant for Public Relations, who has labored long and hard in the effort to implement the policies, projects, and program of activities of this Committee.

Respectfully submitted,
Edgar T. Beddingfield, Jr., M.D.
Chairman

COMMITTEE ON PHYSICAL REHABILITATION

During the year 1959-1960 no referrals of complaints have emanated from private practice in the state which were not adjustable within the framework of current agency operations of (1) Crippled Children Services (2) Vocational Physical Restoration. Your chairman has continued membership with eminent physicians of the Pro-

fessional Vocational Rehabilitation Advisory Committee and through it many problems have been resolved. Otherwise, your committee has been active as indicated by the following schedule.

1. Federal Grants-in-aid Programs:
 - a. Committee requested information as to income limitations for benefits from Vocational Rehabilitation.
 - b. Requests proper follow-up report to examining physician on each Voc. Rehabilitation applicant through District Councilor.
 - c. Questioned the variation in the state as to the requirements of a physical examination on Voc. Rehab. applicants. Asked for better definition of examination requirements.
 - d. Requested some specific information on the medical service programs of Voc. Rehab. to be included in the P. R. Bulletin as general information to all physicians. Also asked to have this information in the State Medical Journal.
 - e. Suggested that each county medical society invite and encourage the local health director to interpret the various functions of the local and State Health Departments and related agencies, such as Voc. Rehab., Crippled Children Service, State Blind Commission etc., for the benefit of all members at regular intervals (at least once a year).
 - f. Requests that emphasis be given on existing regulations that before a patient is fitted with an artificial limb that he be examined by a qualified physician and that before payment is made to the limb-maker that the patient be required to return to the physician for a follow-up examination.
2. Multiple programs of private health organizations:
 - a. The Committee did not feel there was serious overlapping of programs or services.
 - b. No comment regarding operations contrary to public need or extent of problem.
 - c. Master Agency (United Fund type):
The Committee agreed strongly that this matter should be decided by individual physicians and that the State Medical Society should not attempt to state any policy-type of recommendations. It did agree that the economic cost would vary upward under any type of united groupings of agency drives.
3. Consideration given to the application of a Uniform Relative Value Scale:
This Committee feels that before any consideration to a Uniform Relative Value Scale can be applied to public agencies, that it should wait until such a scale has been determined for private agencies, then work towards a comparable scale for public agencies.
4. Old Business:

A letter read by Dr. Goldner from Dr. Pumphry of Bladen County questioning a \$500.00 limita-

tion for rehabilitation.

The Committee questioned if this were a local restriction as no one else had run into such a limitation. Dr. Goldner reported that he had written back for additional information but had received no further answer. The Committee made no comment or recommendation on the matter.

5. New Business

Referred to Committee on Public Welfare and to the Executive Council.

For Educational purposes, this Committee recommends that some note should be attached to Welfare Forms by the Welfare Dept. indicating that the physician receives *no fee* for his services to certified welfare patients.

/s/ George W. Holmes, M.D.
Chairman

COMMITTEE ON RURAL HEALTH AND GENERAL PRACTITIONER AWARD

As Chairman of the State Society's Committee on Rural Health and Education, I submit the following Summary Report on the activities of this Committee and the Health Education Consultant for the years 1959-60.

1. ACCOMPLISHMENT OF 1959-60 OBJECTIVES:

A. Sponsorship of four Area Community Health Conferences

See following Evaluation Report on these area conferences.

B. Joint meeting with Advisory Committee:

In lieu of the proposed dinner meeting as reported in the 1959 annual report, representatives of the State Committee met with the Advisory Committee in Raleigh on September 2, 1959. A thorough discussion of goals, objectives, and accomplishments of this Committee was held.

Recommendations made by Advisory Committee:

- (1) Continue leadership and stimulation of community health activities and programs.
- (2) Assume the initiative in calling together farm and community leaders at local level for program planning and evaluation.
- (3) Reduce the size of areas to be covered by conference programs. Result: the area conferences in 1959 were limited to four or five counties instead of the original Medical Society Districts.
- (4) Activate organizational plans for a Safety Committee and for organized medicine to assume leadership and directions.
- (5) Requested that more emphasis be given to county wide health meetings but to continue the area and State Conferences for leadership training and program emphasis.

C. Health Achievement Certificate Awards for

Community Development Clubs:

This was discussed with the Advisory Committee with the recommendation made for the Medical Society's Committee on Rural Health to prepare specific activity and program suggestions to be incorporated in the overall Community Development Score Sheet before any consideration could be given to awards. This to be followed up in 1960.

D. Preparation of Health Education articles for Farm Publications.

Articles have appeared in the Farm Bureau News; Progressive Farmer; and N. C. Grange Newsletter. The Farm Editor of one large state paper has requested specific information on Farm and Home Safety which this Committee has supplied for a series of articles appearing in 1960.

Information prepared for A.M.A. Council on Rural Health for Nationwide use as to Health and Safety Fairs; Conference Programs; and for the Medical Society's 1960 Officers Conference Program.

E. Educational pamphlets to be produced by State Committee for public distribution.

Continued use of previous pamphlets for distribution at Fairs, Conferences and Special Report for Officers Conference in 1960.

F. Education exhibits: Displays used in Jackson County Health and Safety Fair; for the April, 1959 District Conference held in Brevard, N. C. and for the State Dietetics Annual Meeting in Oct. 1959.

G. Renew interest in the formation of a North Carolina State Farm Safety Council.

Following the recommendation of the Advisory Committee in September, 1959, the Chairman of the Committee on Rural Health and Education called a small group of safety leaders together in Raleigh on Nov. 18, 1959 to discuss the need for: organizational plans, and functions of such a State Council. The group unanimously agreed that the Committee on Rural Health and Educational should pursue definite action and recommended another called meeting of a larger group in the Spring of 1960 for official organization. In the interim, the Chairman has appointed special committees to function prior to the Spring meeting. The date of this meeting will be April 1960 in Raleigh.

CONTINUING PROGRAMS FOR 1959-60

1. CONTACT OF STATE COMMITTEE TO DISTRICT AND COUNTY CHAIRMEN:

- a. All reports of committee meetings distributed to county chairmen and Advisory Committee members.
- b. District Chairmen assisted county chairmen in planning area conference programs.
- c. State Committee Members assisted county

- chairmen for special local programs upon request.
2. Continued emphasis given the 4-H Club Health Improvement program.
 - a. One year subscriptions given to all 1959 County Kings and Queens. (a total of 149 subscriptions given by State Medical Society at a cost of \$223.50)
 - b. Gift Certificates presented to County Health winners by Medical Auxiliary representative at local recognition program. At the Buies Creek Area Community Health Conference, the certificates were presented to 4-H Health Winners, from the four counties: Johnston, Cumberland, Sampson, and Harnett by the Medical Auxiliary.
 - c. One trip to National 4-H Congress in Chicago, November, 1959. The recipient was the state 4-H Health Winner.
Cost: \$165.00
 - d. Special recognition certificates presented to the State King and Queen at State College on November 27, 1959, by Mr. William N. Hilliard, Assistant Executive Director, on behalf of the State Committee on Rural Health and Education.
 3. Encouraging Physician Placement Service Program, especially in rural areas.
 4. Continue to be a service committee for the State Medical Society, in that the Committee and the Health Education Consultant cooperate with and serve all Medical Society Committees in bringing specific programs and information to the attention of county and community groups through joint planning committees, conferences, and special projects.
 5. Maintain liaison contact with Advisory Committee Members to help strengthen their interest and participation in community health programs.
Advisory Committee exhibited their strong interest in community health programs by their recommendations at the September 2, 1959, meeting and also by their cooperation in contacting district and county personnel regarding the 1959-60 area community health conferences.
 6. Continue emphasis on "team approach" at county level by:
 - a. Each county medical society to have an active community health committee chairman who will be willing to serve as leader of the health team.
 - b. At least one meeting to be held each year of the county chairmen and representatives of health agencies and other organizations actively engaged in some type of health education or service programs.
 - c. At least one new county health education project be developed and promoted in each district.
 - d. The Medical Society to continue working through existing community organizations to strengthen and direct their health activities.
 - e. Renew invitation to the American Medical Association's Council on Rural Health to hold their National Conference in North Carolina in 1962.
The State Medical Society has issued an official invitation to the Council on Rural Health. Response expected at the 1960 National Conference in Grand Rapids, Michigan.
 7. Attendance and participation in National Rural Health Conferences:
The Chairman of the State Committee and the Health Education Consultant attended the March, 1959, Conference in Wichita, Kansas, and the 1960 National Conference in Grand Rapids, Michigan, February 25-27, 1960.
 8. In the interest of encouraging more educational emphasis on Farm and Home Safety, the Chairman attended and participated in a special workshop sponsored by the National Safety Council in Chicago—Sept. 31-Oct. 2, 1959. As the sole representative of organized medicine, the Chairman reported that this was in area of work that needed strong medical leadership and participation and therefore came back to North Carolina with the conviction that the Medical Society would take definite follow-up steps in organizing an N. C. Farm Safety Council in 1960. This preceded the November 18, 1959, meeting at which time a report was given to a small "steering committee" group and as a result the April 8, 1960, organizational meeting was requested.
- EVALUATION OF AREA COMMUNITY HEALTH CONFERENCES:**
AREA COMMUNITY HEALTH CONFERENCES: The State Medical Society through its Committee on Rural Health and Education recently sponsored four area Community Health Conferences. The Advisory Committee made up of some 18 different agencies and farm organizations, all interested in promoting better health practices and services through out the state of North Carolina, requested that the areas of the state be broken down into smaller groups as distances are great and prevent representative attendance. Three of the conferences involved four counties each, and the fourth included five, making a total of 17 counties officially invited to participate in the 1959-60 conferences. We had representation from 23 different counties in all four conferences. Attendance ran over 300 persons with two-thirds or more being new contacts for conference participation. The closer such meetings are held, the greater the representation of local and county groups.
Organizations and agencies most frequently represented were:
Medical Society, Public Health Department, extension service, home demonstration and 4-H Clubs, Community Development Clubs, Farm

Bureau, Grange, Welfare Department, City and County Government, Medical Auxiliary, Hospitals, Insurance Companies, Nurses Association, voluntary health agency representatives, cancer, T.B., Heart, and Polio, Ministerial Association, Newspaper, and Federated Women's Clubs.

Among the major health needs reported on the evaluation sheets submitted after each conference were: more emphasis given to family health practices and preventive community health programs; nutrition education for both young and older persons; improved sanitation in our rural and sub-urban areas, especially garbage disposal; need for regular physical and dental check-ups; and the ever present need for additional health and medical personnel outside of our larger population centers.

Community health programs and activities the groups were already engaged in promoting were: visits to cancer detection clinics; T.B.; X-Ray; voluntary health campaigns; immunization programs; including tetanus; community clean-up drives; mental health education; scholarship projects for nursing education and other allied health careers; and better nutrition programs for 4-H and parent groups.

Each group indicated their sincere interest in securing the cooperation and participation of their local physicians and health personnel for guidance and direction as to their health efforts. The bid for county conferences was most pronounced by each group and they wanted the physicians to help them plan, enact, and evaluate their health program.

Similar conferences at the county level would stimulate leaders. From the county reports given by representative leaders, one would know that much was being done across the state in health education and that these efforts could be multiplied once the spark was started and the necessary encouragement given by recognized health and medical leadership.

The State Committee stands ready at all times to assist county chairmen and community leaders with specific program planning and hopes to see the seeds of community action take root and develop into full grown programs within the next year. If these seventeen counties will join others, already engaged in an active local program, many of the problems so cited by these leaders will cease to exist. This is the challenge we pass on to you in your local medical societies.

Conferences were held as follows:

NORTH WILKESBORO—November 10, 1959

Wilkes, Ashe, Alleghany, and Watauga

BUIES CREEK, N. C., CAMPBELL COLLEGE—November 17, 1959

Harnett, Johnston, Sampson, and Cumberland

AHOSKIE, N. C.—December 9, 1959

Gates, Hertford, Bertie, and Northampton

PFEIFFER COLLEGE, MISENHEIMER, N. C.—January 6, 1960

Cabarrus, Anson, Union, Stanly, and Montgomery

Our sincere thanks to the district chairmen, the county medical societies, and county chairmen, program participants, Advisory Committee, and the county organizations and agencies for their splendid cooperation and support given to these conferences.

PROJECTIONS FOR 1960-61:

1. Complete commitment to stimulate formation of a North Carolina Farm Safety Council. (Organizational meeting called for April 8, 1960)
2. Promote and sponsor State Community Health Conference for 1960 (date set for June 29, 1960, Sir Walter Hotel, Raleigh, N. C.)
3. Sponsor four area Community Health Conferences in 1960-61. (Areas to be similar to the 1959-60 conferences—in different sections of the state)
4. Assist in all spontaneous community health programs, projects, conferences, and demonstrations.
5. Perfect coordination of objectives and purpose of the Academy of General Practice Committee on Rural Health with that of the State Medical Society's Committee on Community Health and Safety program.
6. Continue projects already itemized under "continuing projects" in this report.
7. Attend and participate in the A.M.A. Council on Rural Health's Regional Conferences scheduled for 1961.
8. Renew invitation to A.M.A. Council on Rural Health to hold a Regional Conference in 1962 in North Carolina.

/s/ Hugh A. Matthews, M.D.
Chairman

COMMITTEE ON SCHOOL HEALTH AND STATE COORDINATING SERVICE

Those concerned with improving the health of school children are concerned with interpersonal relationships and also with inter-professional and interagency relationships. The problem is how can we develop teamwork among physicians, administrators, nurses, psychologists, teachers, parents and others. This teamwork must not be limited to individuals, but must include organizations and agencies concerned with education, medicine, public health, nursing, dentistry, and others. It is a tremendous problem, but one which must be solved if progress is to be made.

A listing of some of the procedures that are necessary to protect and improve the health of children will provide a foundation for later discussion of ways by which teamwork can be developed. To live and grow healthfully children need:

1. Homes which provide shelter and in which love and affection can be given and received.
2. Adequate amounts of nutritious foods.
3. Opportunities to play with other children.
4. Periodic medical and dental care, including

preventive immunizations.

5. Communities which are sanitary, safe, and wholesome.
6. Community organizations that promote the health and welfare of children and youth.
7. Schools which help them to develop their potentialities and to become acquainted with the world in which they live.
8. Education to help them learn how individual and community health can be maintained or improved.
9. Hospital facilities for use if needed.

Developing teamwork is an art and is developed only by practice. Good results are most likely to occur when practice incorporates knowledge of the feelings of human beings and the way feelings affect behavior. With practice we can all become better members of the school health team.

FIRST MEETING OF COMMITTEE

The Advisory Committee on School Health of the Medical Society of the State of North Carolina has held three meetings since its appointment on June 8, 1959. (Each meeting was attended by a quorum of its membership).

The first meeting held on August 15, 1959, in Raleigh was for the purpose of orientation and information with review of the 1958-59 recommendations and plans for follow-up and new areas of committee activities.

Information regarding specific programs of the schools, PTA and special interest groups presented at the meeting included:

The Governor's Youth Fitness Committee
 The 1960 White House Conference on Children and Youth
 Psychological Testing of Students in the Schools
 Health Careers—a special project of the N. C. Health Council

At the business session the members discussed the following items:

1. The purpose of this meeting was to review the 1959 annual report and to plan necessary follow-up activities. The three major recommendations of this report were adopted as the basic plan of work for 1960 with major focus on the appointment of county chairmen and formation of county committees involving the local physicians, school leaders, public health officials, PTA and other interested community groups to study present programs, services, and to initiate local action programs.

- (a) Appointment of County Medical Society School Health Committee Chairmen; formation of County School Health Committees for local planning and evaluation.
- (b) Recommends that representation from the Committee be present at the AMA 7th National Conference on Physicians and Schools in October, 1959.
- (c) Continued medical leadership and guidance

in all phases of the school health program in N. C.

2. The Committee recommended that the Chairman attend and participate in the 7th National Schools-Physicians Conference to be held October 13-15th 1959, in Highland Park, Illinois.

3. In discussing the role of this Committee, it was agreed that it should be called a "coordinating" committee rather than "advisory" per se and should be an active committee at state and local levels, rather than a passive one.

4. A suggested budget was read and approved. A total of \$506.00 for the year 1960. Items included:

- | | |
|---|----------|
| a. Chairman's expense to National Schools-Physicians Conference | \$150.00 |
| b. Expense of State School Health Conference for 1960 | 250.00 |
| c. Miscellaneous Committee expense | 100.00 |

Budget given to Mr. Barnes to submit to Finance Committee meeting the following day, August 16th, 1959.

5. The Committee agreed to sponsor a state School Health Conference in 1960 and authorized the Chairman to appoint a sub-committee to begin making program plans.

6. To initiate county activity, each member of the Committee was asked to assume leadership in his own respective county, making contacts with schools leaders, PTA, Health Department and County Medical Society in the interest of improving present health instruction, school environment, and health services to and for school children.

7. Under new business which stemmed from the program during the first part of the committee meeting, the following recommendations were made and approved by members:

- a. Committee members to serve on a speaker's bureau for the PTA attending and participating in various conference, workshops, and training institutes.
- b. Consideration of the need for minimum standards for medical supervision and medical examinations. It was suggested that the chairman contact the President of the Pediatric Society as to this group's suggestions and recommendations.
- c. Learning of the Governor's Committee on Youth Fitness, it was suggested that this Committee have a physician serving as technical consultant to assist and give guidance to their program of activity. The Chairman was asked to follow through on this recommendation.
- d. Mr. Spencer had discussed earlier the textbooks used in elementary and high schools and the required health and physical education courses. The committee requested some medical consultation be offered to assist in the selection of text books.
- e. The need for a uniform physical examination form that could be used for multiple

requirements, such as school athletics, 4-H camp, boy scouts, and other special activities which now require separate examinations was discussed and agreed that one form could serve all purposes.

SECOND MEETING OF THE COMMITTEE

The second meeting of the committee was held in conjunction with the meeting of the other committees and the House of Delegates of the State Society at Pinehurst on September 24, 1959.

The Chairman reported on the Regional Conference on School-age children held September 9-11 at the University of North Carolina. A detailed report was mailed each committee member and a brief resume is attached to this report. (Exhibit A)

To assist the chairmen in carrying out committee functions the following subcommittee chairmen were appointed at this meeting:

1. Textbook review evaluation—Dr. Jean Craven
The 9th grade health textbook comes up for renewal next year according to a report from Mr. Charles Spencer of the School Health Coordinating Service. Dr. Smathers asked each member to review this textbook and make their comments to Dr. Craven.
2. Youth Fitness Committee—Dr. Floyd Knight, Chairman, was requested to contact Bob Cox, Executive Director of the Governor's Youth Fitness Committee and the Medical Society and to encourage cooperation between the two groups.
3. State School Health Conference—It had been recommended to this Committee to hold another state-wide conference in 1960. The date of the conference will be set at an early date and work on the program begun at once by the entire committee.
4. Requests made to North Carolina Pediatric Society—Dr. Charles Gay, Chairman. To prepare minimum standards for health supervision and also minimum standards for physical examination of school age children in cooperation with the PTA's continuous health supervision programs. Also to study the advisability of a standard form for reporting physical examinations of school children.
5. A suggested guide for county school health committee chairmen has been prepared as an aid to these physicians in stimulating and promoting local school health programs and activities and is to be mailed to local societies.

Committee report to Executive Council;

1. Request of this committee that consideration be given to having time set aside at the Officers Conference for County Committee Chairmen to meet with State Committee for orientation and stimulation of local action or study programs. Request referred to Public Relations Committee.
2. School Health Committee to sponsor a State School Health Conference in the fall of 1960.

Request for funds included in the 1960 budget proposal.

THIRD MEETING OF THE COMMITTEE

The third meeting of the committee was held in Raleigh on March 12, 1960 for the purpose of reporting the activities of the committee members, evaluating the work of the committee and making recommendations for future committee activities.

It followed the following agenda:

1. Progress report on review of textbooks with recommendations—Dr. Craven of the committee.
2. Reports on Schools—Physicians Conference, October 1959—Mrs. Annette Boutwell and Dr. Irma Henderson Smathers. (Reports attached)
3. Continued emphasis given to local medical society committees on school health—report of Dr. Hunter.
4. Continued cooperation with PTA state, district, and local for educational programs and services—report of Dr. Gay.
5. Better understanding of community health and medical services both private and public for school-age children—this the teachers, parents and physicians need to have as basic information. Report of Dr. Hunter.
6. Question of physical examination (blanks, minimum standards for examination and medical supervision—report of Dr. Gay.
7. Youth Fitness Program in North Carolina—report of Dr. Knight.
8. School Health Fund—report of Charles Spencer.
9. Report of School Health Workshop held at the U.N.C. last summer—Brief resume—Dr. Irma Henderson Smathers.
10. Information on Proposed School Health Workshop to be held at High Point College next summer with recommendations to the Committee—Dr. Gilman Hertz.
11. Recommendations for the new Committee.

The most important items discussed were:

1. The revision of the 9th grade health textbook was considered a great improvement over the current text. Dr. Craven and Dr. Gay have reviewed them. Mr. Spencer will be so advised.
2. Expressed interest in the High Point College Workshop. Two members of the committee are serving on the Advisory Committee for the workshop. (Annette Boutwell and Dr. Irma Henderson Smathers)
3. The Committee voted to cooperate in every way possible with the Youth Fitness Program and suggested this be included on the State Conference Program next fall.
4. In discussing county committees, it was recommended that the chairman before the State Meeting, get out a letter to all presidents and secretaries of county societies and District Presidents and Secretary asking that they appoint a local school health committee. This

will be done at once.

5. A Sunday was suggested as the day of the week for the state conference. No suggestion as to month.

Suggested topics for the Conference program included:

- a. A report on the School-Health Fund expenditures, with county breakdowns. (These will be furnished by Mr. Spencer for as many counties as practical).
- b. Attention be given the ball player who is on 2nd or 3rd team, but who exhibits in daily practice and effort a willingness to participate and to contribute and some reward be given these players who help make it possible for the first team to win.
- c. A report on the present study in North Carolina of problems and practices related to children who are immature at school entrance be made to the conference.
- d. In view of the 1960 White House Conference on Children and Youth—Dr. Susan Dees of Durham is a delegate, be asked to give a report on this conference at the state conference next fall.

RECOMMENDATIONS:

1. Continue recommendation of 1957-58 committee that County Medical Societies appoint School Health Committee Chairmen and organize County School Health Committees for local planning, guidance and evaluation of local school health program.
2. In accordance with edict of 1957 State Medical Convention on advice of 1956-57 State Medical Committee plans be formulated and carried forward by this committee, until its successor is appointed, for the program of the fall School Health Conference and that this conference be held on a Sunday during the fall. Specific items to be included on the program:
 - a. A report on the 1960 White House Conference on Children and Youth.
 - b. A report on the activities and plans of the N. C. Youth Fitness Commission.
 - c. A report on the School Health Workshop to be held at High Point College during the summer.
 - d. A report of the committee exploring the area of problems and practices related to children who are immature at school entrance in N. C.
 - e. A report on School Health Fund expenditures.
 - f. A report on the Health Careers project of the N. C. Health Council.
3. All activities of the various subcommittees of of this committee be continued and expanded.
4. A subcommittee on legislation affecting any area of the School Health Program be appointed with instructions to study such legislation and report to the committee with any recommendations for action at any time deemed necessary.

5. The committee continue to offer its leadership and guidance in all phases of the School Health Program in North Carolina.
6. The new committee be appointed and activated as soon as possible in order to continue the committee activities with as little interruption as possible especially to fulfill responsibilities toward the School Health Workshop in the summer and the School Health Conference in the fall, 1960.
7. The name of this Committee be changed from the Advisory Committee on School Health to the Coordinating Committee on School Health and that it become an active committee at state and local levels rather than a passive one.

During the past year of varied activities in the field of School Health this committee concludes that none of our problems have been solved completely and some completely new problems have been added. However, we feel that we are now worried about more important things and confused on a somewhat higher level.

/s/ Irma Henderson Smathers, M.D.
Chairman

COUNTY MEDICAL SOCIETY SCHOOL HEALTH COMMITTEE

EXHIBIT A

The joint Committee on Health Problems in Education of the American Medical Association and the National Education Association and the State Medical Society's Advisory Committee on School Health both recommend each county medical society to appoint a school health committee to give guidance and leadership to local school health programs.

The local committee should be:

1. Familiar with the present health services being given to school-age and preschool children.
2. Take cognizance of existing health problems among school age children.
3. Become aware of the present health education courses being offered in the school curriculum and lend elements of local guidance to these functions.
4. Become familiar with the various physical education activities and programs in elementary, junior high, and senior high schools and sense the impact of these upon the health and well being of youth.

The local committee should serve as liaison contact with:

1. Local school authorities: PTA's County Health Department, and other interested agencies and organizations for planning school health activities and programs.
2. Physical education and health education teachers, coaches, etc., to advise type of physical activities for special athletic programs and the establishment of essential safeguards in protection of youth.

The local committee should:

1. Assist with planning and scheduling of school

examination programs.

2. Make recommendations for stimulating correction programs under proper auspices.
3. Give supervision to general health service activities, and
4. Report back to the county medical society so that local physicians will be aware of existing school health functions and the opportunities to serve the community and childhood, which become the patients of tomorrow.

COMMITTEE ADVISORY TO STUDENT AMA CHAPTERS IN NORTH CAROLINA

The Committee was called to order in the Carolina Hotel, Pinehurst, North Carolina at 1:00 p.m., Sunday, September 27, 1959 by Dr. Richard T. Myers, who served as vice-chairman due to the illness of the chairman. In addition to members of the committee, there were present: Commissioner Dr. Jacob H. Shuford, Mr. James T. Barnes of the Executive Office and Mr. William Hilliard, of the State Society.

At the outset it was pointed out that the 1958 and 1959 Committees Advisory to Student A.M.A. Chapters had initiated excellent organizational plans for chapter activities, and that this organization had taken place accordingly. The participation of the Student A.M.A. Chapters in the Society's state meeting was considered to be successful and of worthwhile interest to the students who attended.

The Committee recommended that the Student A.M.A. Chapters of our three medical schools be further encouraged in their interest in State Medical Society affairs and activities. In consideration of their participation in the May meeting of the Society in Raleigh, the student section program is to be held on Monday evening, May 9, with the chapter at Duke having charge of the planning of the program, including the scientific presentations. It was further recommended that the State Society, as host, sponsor a dinner on that evening for the senior medical students attending. It was the committee's opinion that President Reece should be requested to welcome the students on this occasion and that one of the Councilors be asked by the Executive Director to discuss with them in general the organization and activities of the State Society and its relation to the Student A.M.A. group.

It was agreed that bus transportation should be again provided for the senior students from each of the three medical schools attending the State Society meeting in Raleigh; the details and final arrangements of which should be worked out by the Executive Director, Mr. James T. Barnes. Likewise, it was the committee's opinion that a block of rooms at the Carolina Hotel be made available by the State Society for use of those senior students who should desire to spend Monday night, May 9, in Raleigh. It was noted that an amount sufficient to cover the cost of the dinner and the hotel rooms had been budgeted by the Committee on Finance.

Mr. Barnes was asked to pass on to each of the three Alumni groups this information and the suggestion that the senior students from the respective schools be invited as guests to the Tuesday Alumni luncheons. In addition, the three Student A.M.A. Chapters were to be asked to notify the Executive Office of their officers to be selected for the current year.

The Executive Director has reported that the Committee on Finance has approved and budgeted an amount adequate to pay travel and subsistence expenses of one delegate from each of the three Student A.M.A. Chapters to the annual National Meeting of Student A.M.A. to be held this May in Los Angeles.

/s/ John P. Davis, M.D.
Chairman

COMMITTEE ON VETERANS AFFAIRS

This Committee, during the year 1959-1960, met in Pinehurst September 24, 1959, and in Durham February 11, 1960.

The purpose of this Committee is to provide better care for service connected veterans: (1) The Home Town Care Program provides medical care to the service connected veteran by a Home Town Physician of his choice; (2) Veterans care in V.A. Hospitals and Clinics is not a direct function of this committee, but we are concerned that the Veterans admitted should be service connected and should be given priority for admission, and upon discharge, a medical summary be sent to the Home Town Physician with authorization for follow-up therapy; (3) Professional relations—Through an intermediary we publish and distribute the fee schedule, disperse information pertinent to changes in the program, and by direct visits to physicians, instruct the physicians and their secretaries in the appropriate procedures to complete the necessary reports and billings. Through the same intermediary we instruct the physician as to the eligibility of the veteran for the specific disability for which he is service connected and so avoid treatment and billing for illness for which the veteran is not eligible.

On June 30, 1959 a new contract with the Veterans Administration was signed for one year. This contract was not what we wanted and need, but through the encouragement of the American Medical Association, we agreed to participate, and so give the A.M.A. more time to work on the problem with other states to induce more states to establish intermediary agencies.

The major criticisms of the new contract are as follows: (1) Our intermediary, the Hospital Saving Association, has been stripped of authority under the guise of economy, and is limited to merely paying bills as specified by the V.A. Regional Office in Winston Salem, N. C. (2) The information on Veterans and Doctors participating is limited to I.B.M. cards supplied by the V.A. (3) Our Contact Officer in the V.A. Regional Office has been forced to resign due to economy.

Mrs. Turbiville, of the intermediary agency in the past, visited physicians and helped their secretaries in routine procedures and also to solve annoying problems. (5) All authorizations for treatment initiate from the V.A. Office and all reports and billings from the doctors are sent to this office. In the past medical reports on chronic illness were required every 3 months, and now monthly despite the fact that authorized duration of treatment may extend for as much as a year at the time. The Regional Office representatives reported that the requirement of monthly reports was initiated in Washington, and they could not change it, much useless reporting is now being required.

In spite of these changes which were reported to the entire membership of our society in a newsletter on June 25, 1959, the participation by North Carolina physicians is far above any other state. There were 1014 physicians paid by the intermediary for care provided veterans through the V. A. Home Town Care Program, for the period January 1, 1959 through September 1959. There are 2,200 physicians registered to participate in North Carolina. A total of \$142,654.83 was paid these physicians—an average of about \$14.00 per physician participating. It is definite evidence that our membership is willing to care for the service connected veteran.

There are 21 physicians, members of the State Medical Society, who treat veterans without utilizing the intermediary. *We invited them to use these facilities on August 28, 1959. None responded.*

At present, the V.A. has begun to negotiate for the next annual contract. They suggested that we permit them to pay the physicians. This we shall refuse, even though the V.A. efficiency during the past calendar year has been satisfactory. The refusal is based on the fact that this is our only means to know who is participating. The only means whereby our members can know that the Medical Society is involved and available to help them if a problem arises. During the year about 20 such problems came to our attention and were corrected.

We would recommend that this committee be continued, that its membership be reduced to a total of 3 or 4, to act as a watchdog, to see that the V.A. properly cares for the ill service connected veteran as well as to deal properly with the physician he selects to treat him.

/s/ S. L. Elfmon, M.D.
Chairman

ANNUAL REPORT OF THE BOARD OF MEDICAL EXAMINERS OF THE STATE OF NORTH CAROLINA—February 1, 1959-February 1, 1960

The State Board of Medical Examiners presents to you, the State Medical Society, the annual report on its activities.

The Board desires to remind the Society that it was just 100 years ago in 1859 through the persistent and good efforts of the members of the

State Medical Society that the bill was enacted setting up the State Board of Medical Examiners.

To commemorate the first 100 years a former secretary of the Board, Dr. Ivan Procter, compiled a very outstanding history, which was published by the Board.

The second biennial registration of physicians went off smoothly, still a few complaints. The total number registered was 5390 when the directory went to press March 31, 1960.

The members of your Board are as follows:

J. B. Anderson, M.D., Asheville, Examiner in Surgery.

Thomas W. Baker, M.D., Charlotte, Examiner in Medicine and Therapeutics.

Joseph J. Combs, M.D., Raleigh, Examiner in Pathology and Bacteriology.

L. Randolph Doffernyre, M.D., Dunn, Examiner in Physiology and Chemistry.

Edwin A. Rasberry, Jr., M.D., Wilson, Examiner in Pharmacology, Pediatrics and Hygiene.

Thomas G. Thurston, M.D., Salisbury, Examiner in Anatomy, Embryology and Histology.

Carl V. Tyner, M.D., Leaksville, Examiner in Obstetrics and Gynecology.

Total number of applicants granted license	332
By written examination	224
By endorsement of credentials	108
Limited License	66
Hospital residents	49
Limited to county or counties	1
Borderline practice	6
Until citizenship obtained	11
Limited converted to full license	11
Special limited license	61
Hospital residents	34
Postgraduate foreign exchange residents	24
Staff state institutions	3
Written examination failure	4
Part I	0
Part II	4
Applicants rejected license by endorsement	0
Applicants declined permission to take written examination	0
Hearings	13
Narcotic addiction	8
Appeal reinstatement of license	2
Violation Narcotic law	1
Convicted Superior—criminal abortion..	2
Investigation State Bureau of Investigation	2
Violation narcotic law	1
Criminal abortion	1
License revoked	4
Convicted Superior Court—criminal abortion	2
Narcotic addiction	1
Narcotic addiction—judgment suspended	1
Narcotic license surrendered	3

Narcotic addiction	3
License reinstated	0
/s/ J. B. Anderson, M.D. President	
/s/ Jos. J. Combs, M.D. Secretary-Treasurer	

COMMITTEE LIAISON TO THE INSURANCE INDUSTRY

The Committee for Liaison to the Insurance Industry has been definitely active in the interest of its objectives during this past year. Several joint meetings of this Committee have been held with the comparable committee from the insurance industry. In camera meetings of the medical committee were also held.

Many of the activities of this committee have and will not come to the attention of the members of this society, because of a primary function of this group—that of liaison. The committee does desire to record that the joint sessions in liaison have been most cordial and highly instructive to both groups. We sincerely believe that many misunderstandings between Medicine and the Insurance Industry in this state have been clarified.

At this point we suggest that the members of this society become acquainted with the function and activities of the Health Insurance Council. This is a national organization made up of the majority of the associations and societies within the insurance industry. They have given freely of their research facilities to us and have assisted greatly in the forwarding of some of our accomplishments for the year. In passing we would however, comment that some of the carriers with which there is a continuing area of dissatisfaction are not actively members, by association, of the Health Insurance Council.

As a part of this committee's function, one of its members, Dr. Mohr, assisted by the research facilities of the H.I.C., has prepared and edited for publication a series of articles dealing with health insurance. Two of these articles have been published in our own state journal. The third article is ready for publication and the fourth is being prepared. Dr. Hawkins, a member of the committee has, with similar assistance, compiled a waiting-room pamphlet dealing with health insurance topics. This will be in the hands of the members of this society quite soon and will be for the benefit and instruction of the public—our patients.

Other members of the committee are presently at work on various facets of the function of this committee, which, as of this time, have not reached the state of fruition. Among these projects is a program to promote "front end" deductible health and accident insurance rather than first dollar coverage. Another is to further explore the need for coverage of diagnostic procedures on an out-patient basis. A third is a fairly intensive study of the feasibility of the establishment of a Medico-Insurance Review Board or

Commission, whose function would be to concern itself on a hypothetical basis with "specific" items of contention relative to the adjudication of claims and other matters. This function would in no way be legal or quasi-legal and its basic aim would be to forestall other and more unhappy means of arriving at a meeting of minds. Another member of this committee has arranged for speaker panels on insurance topics which will be available to county societies.

Representation in an informal way has been made in proper places relative to so-called "small loan health insurance". Similar comment has been forwarded both formally and informally relative to violations of the State Codes regarding misrepresentation of health insurance contracts, most especially by agents.

A pamphlet containing the approved claim forms for the reporting of health insurance claims has been mailed to every physician in the state. It is pointed out to the society that the use of these claim forms is mandatory (q.v. the ruling of Mr. Charles F. Gold, The Commissioner of Insurance for North Carolina). We understand that a few "hardship deviations" have been allowed by the Commissioner's office and we are presently attempting to secure advice on this.

Joint efforts against certain unwise social legislation have been carried out. These and other matters have fully occupied this Committee.

During the year all of our meetings have been participated in by either Mr. Barnes or Mr. Hilliard and we are fully grateful for their assistance and counsel. We have also been favored with the presence of our president-elect, Dr. Amos Johnson, our Commissioner, Dr. Hubert Poteat, certain chairmen of other society committees and other members of the higher echelons of the Society from time to time. Mr. Commissioner Gold, along with a part of his staff, also participated in one of our joint sessions. It is felt that we can say that the Commissioner was pleased with our current and projected activities.

In closing this report the Chairman desires to thank the members of the medical committee for their work; to express our appreciation to the members of the committee from the Health Insurance Council and its able Chairman, Mr. Richard Jones of Greensboro, for their honest frankness and gentlemanly bearing in all of our joint deliberations, and finally, to comment that although we have in our discussions pointed out certain unpleasant items relative to the insurance industry, that occasionally some of the members of our own society do not come to the assizes with lily-white hands as witnessed by some of the documents we have seen.

/s/ Frank W. Jones, M.D., Chairman
Jack E. Mohr, M.D., Vice-Chairman
Grover C. Bolin, Jr., M.D.
Andrew J. Dickerson, M.D.

Archie Y. Eagles, M. D.
 Charles I. Harris, Jr., M.D.
 Barry F. Hawkins, M.D.
 Cleon W. Goodwin, M.D.
 Wm. J. Senter, M.D.
 George T. Wolff, M.D.

COMMITTEE ON NECROLOGY

The Committee on Necrology has had one meeting with full consideration of problems related to the responsibility of the Committee and its functions. Procedures have been concluded on the basis of existing policy.

The Committee has again stimulated reckoning of the Necrology Listings of all physicians who have died in the state and where proper has referred information to other state societies for list. For the period April 1, 1959, to April 1, 1960, documentations of physicians deaths have been gathered from divers sources and filed at Headquarters Office. Verifications have been gone into in great detail to assure accuracy.

The Committee has caused the names of deceased to be properly registered for the period as follows: (1) Deaths for 1958-1959 have been published in the Annual Roster of members and organization (2) In like manner, listing of 1959-1960 deaths have been placed in the Official Program of the 106th Annual Sessions.

A Memorial Service program has been planned in cooperation with the Committee on Arrangements and the Headquarters Office to be conducted at the Sir Walter Hotel, Raleigh, N. C., 8:00 o'clock the evening of May 8, 1960, which is during the course of the Annual Sessions. The Women's Auxilliary has planned conjoint memorializing of the deceased wives of physicians at that time.

The Committee is indebted to the Management and Staff Supervisors of Rex Hospital for the cooperation of the Rex Hospital Nurse Choir in arranging for a music presentation appropriate to the Memorial Service on the above occasion.

/s/ Charles H. Pugh, M.D.
 Chairman

COMMITTEE ON CANCER

The meeting of the Cancer Committee was held at Pinehurst September 25, 1959 with the following members present; Doctors Isaac E. Harris, Harry V. Hendrick, Mark M. Lindsey, Charles G. Mock, Alexander S. Moffett, Samuel L. Parker, D. F. Ward, Hubert M. Poteat, Charles Harris, the Chairman, and D. F. Millam, Chief of the Cancer Section of the State Board of Health, by invitation.

There was much discussion of the fact that cancer patients are not being reported to the State Board of Health as required by law. It was decided that the hospital administrators be contacted to see if a more efficient system of reporting could be devised. At present this is being worked upon with that end in view.

The epidemiological study proposed by the American Cancer Society in North Carolina was

approved.

Dr. Mark Lindsey presented the plan for the Cured Cancer Congress in North Carolina to be held in Raleigh in March. One five year cured cancer patient from each County is to be the goal. Each patient is to be recommended by a physician through the county societies. It is hoped that this will be held each year. This organization should be the means of offering hope to those people with cancer. So often people hear of those who die from cancer, rather than of those who are cured.

The Committee heartily endorsed this program.

The Papanicolaou smear campaign being pushed by the Cancer Committee, in co-operation with the American Cancer Society and the North Carolina Society of Pathologists, is making good headway. Most pathologists are reporting increasing requests for smears.

To date there have been 14 county society programs arranged by the Cancer Committee on Papanicolaou smears. These have been well attended. The Committee is ready and anxious to provide speakers for more programs as requested. It is felt that deaths from cancer of the cervix can be almost eliminated if all women would have cervical smears taken at proper intervals.

The Committee feels that further comment is necessary regarding the use of the funds of the State Board of Health for the treatment of indigent cancer patients. There are insufficient funds for the fulfillment of all requests, therefore, the policy has been adopted that funds will be approved for only those patients who have a chance of cure by surgery, x-ray or radium. Due to the lack of funds, requests for funds for palliation must be turned down.

/s/ James F. Marshall, M.D.
 Chairman

REPORT TO THE NORTH CAROLINA MEDICAL SOCIETY ON ACTIONS OF THE HOUSE OF DELEGATES, AMERICAN MEDICAL ASSOCIATION, ONE HUNDRED EIGHTH ANNUAL MEETING, ATLANTIC CITY, JUNE 8-12, 1959 and THIRTEENTH CLINICAL MEETING, DECEMBER 1-4, 1959, DALLAS, TEXAS.

Dr. Blasingame's synopsis of the action of the House of Delegates in Atlantic City covers the main points so well that it probably could not be improved on. Therefore, it is submitted as our report of this meeting.

We would like, however, to call special attention to the fact that the resolution on nurse education submitted by the North Carolina State Society was approved by the Reference Committee on Medical Education and Hospitals, and adopted unanimously by the House of Delegates. This resolution reads as follows:

"RESOLVED: That the Physicians' Committee on Nursing of the Medical Society of the State of North Carolina recommend to the House of Delegates of said Society that the House of Delegates of the American Medical

Association be petitioned to seek by friendly cooperation a more active participating role in nursing education and service in general and, more specifically at this time, to seek medical representation on the Blue Print Committee for State Board Test Pool Examinations of the National League for Nursing. Further that two such medical representatives be selected by the proper committee of the American Medical Association House of Delegates, said representatives to be doctors of medicine who are interested in and familiar with the problems and purposes expressed in the above preamble of this resolution, and physicians who by character and personality are capable of mutual cordial enthusiasm for carrying out these purposes and enthusiastic effort to provide the quality and quantity of nursing needed in this Nation."

The report of the A.M.A. Commission on Medical Care Plans, relations between medicine and osteopathy, the report of the Committee on Preparation for General Practice, and the issue of compulsory Social Security coverage for self-employed physicians were among the major subjects which brought important policy actions by the House of Delegates at the American Medical Association's One Hundred Eighth Annual Meeting held June 8-12 in Atlantic City.

Another high light of the meeting was the appearance of President Dwight D. Eisenhower, who addressed an overflow audience of more than 5,000 at the Tuesday night inauguration of Dr. Louis M. Orr of Orlando, Florida, as the one hundred thirteenth President of the A.M.A. It marked the first time that a President of the United States has addressed an A.M.A. annual or clinical meeting.

Dr. E. Vincent Askey of Los Angeles, speaker of the House of Delegates since 1955, was named president-elect for the coming year. Dr. Askey will succeed Dr. Orr as president at the association's annual meeting in June 1960, in Miami Beach.

The 1959 Distinguished Service Award of the American Medical Association was voted to Dr. Michael E. De Bakey of Houston, Texas, chairman of the department of surgery at Baylor University College of Medicine, for his outstanding contributions in the field of cardiovascular surgery. Dr. De Bakey received the award at the Tuesday night inaugural ceremony.

Total registration through Thursday, with half a day of the meeting still remaining, had reached 28,225, including 12,921 physicians.

EISENHOWER ADDRESS

President Eisenhower, speaking at the inaugural ceremony in the ball-room of Convention Hall, warned that inflation posed the greatest danger to the traditional, free-enterprise practice of medicine. The cost of inflation, he said, "is not paid in dollars alone but in increasingly stagnated progress, lost opportunities, and eventually, if un-

checked in lost freedoms for the doctor and the patient." Mr. Eisenhower also expressed gratification at learning of A.M.A. leadership in the program to meet the health care needs of the aged.

Commission on Medical Care Plans

The House of Delegates received Part I of the report of the Commission on Medical Care Plans as information only and then acted upon the Commission recommendations item by item. The House adopted 36 of the recommendations without change, but reworded three which relate to miscellaneous and unclassified plans. The changed recommendations now read as follows:

- B-4 In an effort to decrease, or at least to prevent an increase, in the over-all cost of health care study should be given to the removal of the requirement of hospital admission as the only condition under which payment of certain benefits will be made.
- B-6 Medical care plans should be encouraged to increase their efforts to provide health education and information concerning the coverage of their subscribers.
- B-16 The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses. Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care and the American Medical Association vigorously supports the right of the individual to choose between these alternatives.

In connection with free choice of physician, the House also requested the Board of Trustees to transmit to all constituent medical associations the "far-reaching significance" of Recommendation A-7, which says:

"Free choice of physician is an important factor in the provision of good medical care. In order that the principle of "free choice of physician" be maintained and be fully implemented, the medical profession should discharge more vigorously its self-imposed responsibility for assuring the competency of physicians' services and their provision at a cost which people can afford.

The House also strongly endorsed Recommendation B-11, which declares that "Those who receive medical care benefits as a result of collective bargaining should have the widest possible choice from among medical care plans for the provision of such care."

Many of the Commission recommendations urged increased activity by State and county medical societies and the American Medical Association in such fields as continuing study and liaison, closer attention to legal and legislative factors, and the development of guides for the relationship between the medical profession and the various types of third parties. To carry out three of the recommendations involving AMA

activities, the House also approved a seven-point program which it requested the Board of Trustees to transmit to the Division of Socio-Economic Activities for immediate attention.

Medicine and Osteopathy

In considering a special report of the Judicial Council on the subject of osteopathy, the House adopted the following policy statement regarding interprofessional relations:

(A) All voluntary professional association between doctors of medicine and those who practice a system of healing not based on scientific principles are unethical.

(B) Enactment of medical practice acts requiring all who practice as physicians and surgeons to meet the same qualifications, take the same examinations and graduate from schools approved by the same agency should be encouraged by the constituent associations.

(C) It shall not be considered contrary to the Principles of Medical Ethics for doctors of medicine to teach students in an osteopathic college which is in the process of being converted into an approved medical school under the supervision of the A.M.A. Council on Medical Education and Hospital.

(D) A liaison committee be appointed by the Board of Trustees of the American Medical Association to meet with representatives of the American Osteopathic Association, if mutually agreeable, to consider problems of common concern including inter-professional relationships on a national level.

In another action concerning osteopathy, the House recommended that the American Medical Association representatives on the Joint Commission Accreditation of Hospitals suggest to the Joint Commission that they inspect upon request and consider for accreditation without prejudice those hospitals required by law to admit osteopathic physicians to this staff.

Preparation for General Practice

The House approved and commended the final report of the Committee on Preparation for General Practice, which proposes a new two-year internship program for medical school graduates planning to become family physicians. To avoid unnecessary confusion, the House deleted only one sentence which read: "Indeed, the committee believes that the one year internship actually encourages inadequate preparation for general practice." The Committee on Preparation for General Practice included representatives from the A.M.A. council on Medical Education and Hospitals, the American Academy of General Practice and the Association of American Medical Colleges.

The suggested program would include a basic minimum of 18 months hospital training in the diagnostic, therapeutic, psychiatric, preventive and rehabilitative aspects of medicine and pediatrics in a very broad sense, including care of the newborn. A physician then could elect to spend

the remaining six months for additional training in other segments of the program. The committee stated, however, that participants who plan to practice obstetrics would be expected to spend at least four months of elective period in obstetrical training.

The report declared that "the graduate program of two years in preparation for family practice should be planned and implemented as a unified whole" with a maximum continuity of assignment in specific services. The program also calls for adequate experience in out-patient care and emergency room service.

Social Security

In considering five resolutions on the subject of compulsory Social Security coverage for self-employed physicians, the House disapproved of four and adopted one reaffirming its opposition to the compulsory inclusion of physicians. In so doing, the delegates expressed concern over the possible effects that a change of policy might have on the Association's entire legislative program, particularly with respect to the Forand Bill.

The House also recognized "the apparent growing demand by physicians for economic security" and requested the Board of Trustees to investigate the possibilities of developing group insurance and retirement plans which could be made available to Association members. It accepted a reference committee suggestion "that the American Medical Association continue and expand its educational program to inform its members of the economic, social and moral advantages of economic security obtained within the framework of our free enterprise system rather than through the mechanisms of governmental Social Security.

Miscellaneous Actions

In dealing with a wide variety of other subjects, the House also: Urged all physicians to participate more fully in community activities and socio-economic matters in their own communities but agreed that no change should be made at this time in Article II of the Constitution, which states Association objectives:

Approved in principle the aims and objectives of the President's Council on Youth Fitness and the Citizens Advisory Committee on the Fitness of American Youth;

Accepted a Board of Trustees recommendation that the 1962 Annual Meeting be held in Chicago;

Expressed heartfelt thanks to the Committee on Amphetamines and Athletes, which has completed its assignment;

Requested the Board of Trustees to study the problems and possibilities of establishing an A.M.A.—sponsored medical scholarship and/or loan program;

Approved the inclusion of Today's Health as a benefit of dues-paying membership and urged members to make it available to their patients;

Recommended that state medical societies,

where advisable, initiate legislative efforts to eliminate cancer quackery;

Received a progress report indicating "phenomenal progress" in the field of health insurance coverage for the aged since the Minneapolis meeting last December;

Gave a rising vote of thanks to Dr. Joseph D. McCarthy, who finished his term as chairman of the Council on Medical Service;

Reaffirmed its full support of the Educational Council for Foreign Medical Graduates;

Endorsed the purposes outlined in the initial report of the Medical Disciplinary Committee;

Urged every A.M.A. member to give a substantial gift to the medical schools through the American Medical Educational Foundation; and

Expressed appreciation for the outstanding disaster medicine program presented by the United States Army Medical Service on June 6, 1959, in Atlantic City.

Opening Session

At the Monday opening session Dr. Gunnar Gundersen of La Crosse, Wisconsin, retiring A.M.A. president, stressed the personal responsibility of every physician to keep abreast of medical advancement and to deliver "1959 medicine." Dr. Orr, then president-elect, called for concerted effort and medical leadership in four areas—the costs of medical care, recruitment of dedicated medical students, basic research, and health care of the aged. Dr. Carl V. Moore, Busch professor of medicine at Washington University, St. Louis, was presented with the eighth Goldberger Award in clinical nutrition. Smith, Kline and French Laboratories of Philadelphia received a special A.M.A. award for its sponsorship of color medical television over the past 10 years.

Inaugural Ceremony

Dr. Orr, in his Tuesday night inaugural address, affirmed his belief in the basic principles of medicine, democracy, and faith under which America's physicians live. He pointed out that freedom must continually be fought for by men and women who are willing to stand up and be counted. Dr. Leonard Larson of Bismarck, N. D., AMA Board Chairman, administered the oath of office to Dr. Orr, and the latter presented the Distinguished Service Award to Dr. De Bakey. The Fort Dix Band Chorus presented the musical program.

Election of Officers

In addition to Dr. Askey, the new president-elect, the following officers were selected at the Thursday Session:

Vice President, Dr. James Stanley Kenney of New York City; speaker of the House of Delegates, Dr. Norman A. Welch of Boston, and vice speaker Dr. Milford O. Rouse of Dallas, Texas.

Dr. R. B. Robins of Camden, Arkansas, and Dr. Hugh H. Hussey, Jr. of Washington, D. C., were re-elected for five year terms on the Board of Trustees. Also elected to the Board, for the first time, was Dr. Percy E. Hopkins of Chicago.

Dr. J. M. Hutcheson of Richmond, Virginia, was re-elected to the Judicial Council. Re-elected to the Council on Medical Education and Hospitals were Dr. Charles T. Stone, Sr., of Galveston, Texas, and Dr. W. Andrew Buntin of Cheyenne, Wyoming.

Dr. Willard Wright of Williston, North Dakota, was elected, and Dr. J. Lafe Ludwig of Los Angeles was re-elected to the Council on Medical Service. Dr. William Hyland of Grand Rapids, Michigan, was re-elected to the Council on Constitution and By-Laws.

REPORT OF ACTIONS OF THE HOUSE OF DELEGATES—AMERICAN MEDICAL ASSOCIATION, THIRTEENTH CLINICAL MEETING, DECEMBER 1-4, 1959 DALLAS, TEXAS.

Freedom of choice of physician, relations between physicians and hospitals, a scholarship program for deserving medical students and relative value studies of medical services were among the major subjects acted upon by the House of Delegates at the American Medical Association's Thirteenth Clinical Meeting held December 1-4, 1959 in Dallas.

Dr. Chesley M. Martin of Elgin, Oklahoma, was named as the 1959 General Practitioner of the Year for his outstanding contributions to the health and civic affairs of his home community. Dr. Martin, who has practiced in Elgin for the past 44 years, was the thirteenth recipient of the annual award and the first Oklahoman to be so honored.

Speaking at the Tuesday opening session of the House, Dr. Louis M. Orr of Orlando, Florida A.M.A. President, urged the nation's physicians to take a more active interest in the whole area of politics, public affairs, and community life. Dr. Orr also asked physicians and medical societies to do a more effective job of telling medicine's positive story, adding that "if more people knew more about the things we support and encourage, they would listen to us much more carefully about those occasional things that we oppose."

Two nationally known political leaders from Texas also addressed the Tuesday morning session. Senator Lyndon B. Johnson, majority leader in the U. S. Senate, called for a "politics of unity" which will enable Americans to exert strength and determination in an effort to create a world in which all men can be free. Speaker of the U. S. House of Representatives Sam Rayburn urged greater attention to the task of educating young people in the principles of American government and giving them a desire to perpetuate it.

Total registration through Thursday, with half a day of the meeting still remaining, had reached 4,727, including 2,742 physicians.

Freedom of Choice

In considering four resolutions which in various ways would have changed or replaced the

statements on freedom of choice of physician which the House adopted in June, 1959, when acting upon the recommendations in the report of the Commission on Medical Care Plans, the House reaffirmed the following two statements approved in Atlantic City:

1. "The American Medical Association believes that free choice of physician is the right of every individual and one which he should be free to exercise as he chooses."

2. "Each individual should be accorded the privilege to select and change his physician at will or to select his preferred system of medical care, and the American Medical Association vigorously supports the right of the individual to choose between these alternatives."

This additional statement was submitted on floor of House:

3. "Lest there be any misinterpretation, we state unequivocally that the American Medical Association firmly subscribes to freedom of choice of physician and free competition among physicians as being prerequisites to optimal medical care. The benefits of any system which provides medical care must be judged on the degree to which it allows of, or abridges, such freedom of choice and such competition."

Physician-Hospital Relations

The House received 12 resolutions on the subject of relationships between physicians and hospitals. To resolve any doubt about its position, the House did not act upon any of the resolutions but instead reaffirmed the 1951 "Guides for Conduct of Physicians in Relationships with Institutions." It also declared that "all subsequent or inconsistent actions are considered superceded."

The House also accepted recommendations that (1) the House of Delegates acknowledge the need to strengthen relationships with hospitals by action at state and local levels, (2) the Board of Trustees of the Association continue to maintain liaison with the Board of Trustees of the American Hospital Association, and (3) the Council on Medical Service review this entire problem to ascertain if there have been actions inconsistent with the 1951 Guides.

Those Guides summarize the following general principles as a basis for adjusting controversies:

"1. A physician should not dispose of his professional attainments or services to any hospital, corporation or lay body by whatever name called or however organized under terms or conditions which permit the sale of the services of that physician by such agency for a fee.

"2. Where a hospital is not selling the services of a physician, the financial arrangement if any between the hospital and the physician properly may be placed on any mutually satisfactory basis. This refers to the remuneration of a physician for teaching or research or charitable services or the like. Corporations or other lay bodies properly may provide such services and employ or otherwise engage doctors for those purposes.

"3. The practice of anesthesiology, physical medicine and radiology are an integral part of the practice of medicine in the same category as the practice of surgery, internal medicine or any other designated field of medicine."

Scholarship Program

To help meet the need for an increasing number of physicians in the future, the House approved the creation of a special study committee which was asked to:

1. Present a scholarship program, its development, administration and the role of the American Medical Association in fulfilling it.

2. Ascertain the maximum to which medical schools could expand their student bodies while maintaining the quality of medical education.

3. Ascertain what universities can support new medical schools with qualified students and sufficient clinical material for teaching—either on a two year or a full four year basis.

4. Investigate the securing of competent medical faculties.

5. Investigate financing of expansion and establishment of medical schools.

6. Investigate financing of medical education as to the most economical methods of obtaining high quality medical training.

7. Develop methods of getting well-qualified students to undertake the study of medicine.

8. Investigate the possibility of relaxing rigid geographic restrictions on the admission of students to medical schools.

The House urged that the special committee be implemented promptly with adequate funds and staff so that it may make an initial report by June, 1960.

Relative Value Studies

Reaffirming a previous policy statement, the House approved in principle the conducting of relative value studies by each state medical society, rather than a nationwide study or a series of regional studies by the A.M.A. The House also reiterated its authorization for the Committee on Medical Practices to inform each state medical association, through regional or other meetings, of the purpose, scope and objectives of such studies, the steps to be followed in conducting studies, the problems which may be encountered, and the manner in which the results can be applied.

The House recognized, however, that some state medical societies are either not interested in relative value studies or are actively opposed to them. It pointed out that some state medical associations fear that the regional conferences of the Committee on Medical Practices will put pressure on them to carry out such studies and that this will result in the adoption of "fixed fees."

Since the regional conferences are educational in nature, the House said it remains for each state or county medical association to accept or reject the idea of a study in its area.

The House expressed awareness of the fact that this is still a controversial matter. It commended the Committee on Medical Practices, however, for its effort to carry out the instructions of the House, and it urged the committee to continue its educational work.

Miscellaneous Actions

In considering 44 resolutions and a large volume of annual, supplementary, and special reports, the House also:

Learned that the A.M.A. Board of Trustees has appointed a liaison committee to meet with a similar committee of the American Osteopathic Association to consider matters of common concern;

Emphasized that local medical societies should insure that no member violates ethical traditions as they relate to ownership of pharmacies or stock in pharmaceutical companies;

Approved the plan of the Committee on Medical Rating of Physical Impairment to publish its new guide on the cardiovascular system in the A.M.A. Journal;

Recommended that Association councils and committees, whenever feasible hold their meetings in the remodeled Chicago headquarters;

Called for investigation of the need, desirability and feasibility of establishing a home for aged and retired physicians;

Commended Dr. F. S. Crockett, retiring chairman of the Council on Rural Health, for his many years of devoted duty;

Urged active promotion and careful study of the newly developed "Guides for Medical Care in Nursing Homes and Related Facilities";

Suggested that fees for consultative examinations under programs of the Bureau of Old Age and Survivors Insurance should be adjudicated directly between the state medical society and the state agency involved;

Registered a strong protest to the Veterans Administration, urging stricter screening of non-service-connected disability patients admitted to government hospitals;

Reiterated the Association's support of Blue Shield concept and directed the Council on Medical Service to submit at the June 1960 meeting its recommendations concerning a policy statement on A.M.A. relationship with Blue Shield plans;

Suggested that S. J. Res. 41, a bill which would institute a separate program of international medical research, be delayed until an over-all assessment can be made of proposals now before Congress dealing with domestic and international medical research;

Endorsed the program of the Educational Council for Foreign Medical Graduates but also urged that judicious consideration be given to local problems involved in the July 1, 1960, deadline for certification of foreign graduates;

Urged that medical schools include in their curricular a course on the social, political, and

economic aspects of medicine;

Declared that threat of nuclear warfare has imposed a tremendous responsibility on the medical profession, which must be prepared to assume a critically important role in such an event;

Suggested that the A.M.A. make available to school libraries information and literature showing the advantages of private medical care and the American free enterprise system;

Stated that examinations to determine the physical and mental fitness of aircraft crew members should be made by doctors of medicine with special knowledge and proficiency in certain techniques;

Urged the American people to get proper tetanus toxoid, original and booster, and other immunizations as indicated from their physicians, and called on A.M.A. members to cooperate in an educational program on tetanus immunization;

Recommended that all state and county medical societies establish programs for the inspection and testing of all fluoroscopes and radiographic equipment;

Approved the Speaker's proposal that the opening session of the House, at the Interim Meeting, be moved from Tuesday morning to Monday morning, with the reference committees meeting on Tuesday and the House reconvening on Wednesday afternoon;

Called upon each individual physician to wage "a vigorous, dynamic and uncompromising fight" against the Forand type of legislation;

Urged state and local medical societies and individual physicians to implement the A.M.A. program for recruitment of highgrade medical students;

Changed the title of the Section on Surgery, General and Abdominal, to the Section on General Surgery;

Accepted with appreciation a \$2,500 contribution by Smith, Kline and French Laboratories toward establishment of a suitable award honoring the name of Dr. Thomas G. Hull, retiring secretary of the Council on Scientific Assembly, and

Reaffirmed the "Suggested Guides to Relations between Medical Societies and Voluntary Health Agencies," which were adopted at the December, 1957, meeting in Philadelphia.

Charles F. Strosnider, M.D.

Millard D. Hill, M.D.

Elias S. Faison, M.D., Secretary

PUBLIC RELATIONS ANNUAL REPORT of

William N. Hilliard

It is sincerely hoped that my activities in the field of public relations for the Medical Society of the State of North Carolina have, over the past year, continued as a contribution to the development of programs which are in the best interest of the Society. That most assuredly is the aim toward which our personal efforts have been

expended.

The wise guidance and suggestions of the Committee on Public Relations are responsible for whatever success has been achieved in behalf of the Society. Dr. E. T. Beddingfield, as chairman and Dr. Ralph Garrison and Dr. W. J. Senter as members of the Committee have always given generously of their time whenever it was sought. Mr. James T. Barnes, your Executive Director, has always played a large part in channeling your Public Relations Assistant's efforts in the direction that would be most beneficial to the interests of the physicians in the State.

Whenever possible we have done our best to coordinate our efforts with the work of the Executive Director, assisting him whenever possible, as well as working with the various projects undertaken by other Committees of the Society.

The Public Relations Bulletin has been edited on a basis of nine issues a year, publishing it monthly except for the months of May, July and August. We have achieved to make the Bulletin as newsworthy and brief as possible for expeditiously reaching the membership with messages and information of importance. The device of enclosing material in the mailing with the Bulletin describing the activities of various Society committees or of other information of importance to the membership is growing in popularity.

The Conference of County Medical Society Officers and Committeemen, sponsored by the Committee on Public Relations on January 29, 1960, involved a considerable amount of effort in the prior fall period. Workbooks as reference material for the various County Society Officers were developed and distributed at the meeting.

Under the supervision of the Committee on Public Relations a State Fair exhibit was developed in the name of the Society and displayed at the N. C. State Fair covering the period October 13-17, 1959. The display used as its educational theme the comparison of the national monetary totals expended for several pleasure items as favorably compared with expenditures for health care items. The exhibit also offered an opportunity for people to get their blood type determined and receive pocket size identification card indicating this information. The fair exhibit provided an excellent opportunity for the distribution of educational materials.

A "Reference List of Medical Spokesmen" comprising the County Medical Society Presidents, Secretaries, and Chairman of the Committee on Public relations was developed, printed and distributed to the newspapers throughout the state as a continuing effort in behalf of promoting mutual understanding between the medical profession and representatives of the information media.

The distribution of first aid charts and other educational materials has been continued on an

"on request" basis. The first aid charts continue to be a popular project of schools, extension groups, and civic clubs. The low printing cost of this item is certainly considered a valid and worthwhile expenditure.

The Headquarters Office continues to serve as a distribution point for transcribed radio programs produced by the American Medical Association. Approximately 15 different series of programs of 15 minute duration each on medical and health topics are available for County Medical Society use over local radio stations. Each series or topic contains 13 of the 15 minute programs and have been well received by radio stations using the programs.

A new series of transcribed radio programs, five minutes in length, entitled "Medical Milestones" have been distributed and used by more than 50 stations in North Carolina as a cooperative project of the State Society and the American Medical Association. Volume I and II have already been distributed and Volume III is in preparation. This series of 13 five minute radio programs entitled "Medical Milestones" have received many favorable comments from the Broadcast industry.

The two day Annual Public Relations Institute of the American Medical Association was attended in Chicago last August 20-21. Attendance at this session offered an excellent opportunity for the exchange of ideas with other persons employed in other states in a similar capacity.

The printing and distribution of a booklet based on the exhibit developed by the Committee on Medical Credit Bureau was a project undertaken in cooperation with that committee. The booklet proved to be of considerable interest to physicians and to the recognized collection agencies. The exhibit will be shown again at the 1960 Annual Session in Raleigh where copies of the booklet will be available.

Another project currently being undertaken in cooperation with the Committee to work with the Industrial Commission of North Carolina, is the printing and distribution of a "Guide for Permanent Disability Evaluation of Industrial Accidents." Current plans now call for the distribution of this booklet as an enclosure with the June issue of the Public Relations Bulletin going to all members of the Society.

In any discussion of the topic of public relations it must be realized that many things can be accomplished through a single public relations representative. The composite image of any profession is a result of the public relations awareness and efforts of the professions' entire membership. Doing good deeds and getting credit for them is not necessarily the completion point of one's efforts. It must be kept in mind that frequently a profession must furnish an interpretation of their stand or deeds.

The future of American medicine hinges upon the sentiment of the public for your medical care

system and you as medical men, therefore it is of the utmost importance that your patients and acquaintances understand the advantages of the free choice of physician system of care.

Thus your attention is called to the words of Leo Brown, Director of Communications for the American Medical Association, when he stated . . . "The art of communicating and its importance in interpreting human events and opinions is recognized as one of our most pressing problems in the development of an effective public relations program."

Statistical reference is made to the following tabulation with regard to the public relations mailings:

April 20, 1959-April 20, 1960

Mail Received	2,345
Mailed	11,114
Press Releases	549
Films	33
Radio Transcriptions	185
Public Relations Bulletin	26,335
Long Distance Telephone Calls	174

/s/ William N. Hilliard
Executive Assistant
for Public Relations

ANNUAL REPORT OF THE PRESIDENT OF THE AUXILIARY TO THE MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA 1959-1960

It is with great pride and pleasure that I submit this report of the activities of the Auxiliary to the Medical Society of the State of North Carolina. In this, our 37th year, much good work has been accomplished and substantial progress has been made. This can be attributed to the loyalty, the cooperation, the infectious enthusiasm and the unswerving dedication of our members. My year as President of the Auxiliary will always remain one of my cherished memories, and I am grateful to the officers, councilors, committee chairmen, county presidents, and to all our members, who proved so ably that there is real joy in "Service to Others."

The actual work for your President began well before taking office. Committee chairmen had to be secured and many plans and preparations made. A most enjoyable President-Elect's Luncheon during the Convention in Asheville in 1959 outlined the areas of major emphasis for the year. Dr. W. Reece Berryhill, Dean of the School of Medicine, University of North Carolina, spoke on American Medical Education Foundation and the great need for continued support of this national project. Dr. Eugene Hargrove, Director of the State Hospitals Board of Control, spoke on Mental Illness and what could be done to help in this major public health problem. Thus the corner stones for the year's work were laid: A.M.E.F. and Mental Illness. Other projects of State and National importance would be continued or added later. The Luncheon was attended by in-coming and out-going State and County

Officers, Committee Chairmen and Councilors, the captains of the team which would attempt the difficult task of continuing the work so hopefully begun by others.

It was my privilege to attend the Convention of our National Auxiliary in Atlantic City in June. We had our full complement of Delegates: seven, plus the Presidential Delegate, and we attended all sessions. These were informative, and helped us plan further for our own year's work. We received much inspiration from our National leaders, and felt a great surge of pride in being part of a national organization of some 80,000 members, all dedicated to the same ideals of better health and better living for all. The new National President, Mrs. Frank Gastineau, used as her theme for the year "Individual Responsibility for Better Community Health." This gave us the keynote for our work: the success of any organization *begins with the individual*.

The summer months were crowded with plans and preparations for the Fall Board Meeting and Workshop and the compilation of our new year-book, GUIDE POSTS. GUIDE POSTS has a cover designed specially for us and can be used indefinitely, if the Auxiliary wishes. The little "signs" can be changed from year to year as projects or emphases change. It is my pleasure to donate this cover design to the Auxiliary, to be used as the members wish. The book itself gives comprehensive coverage of Auxiliary work, instructions, general information, and rosters. It was very well received and our members have found it most helpful throughout the year. The Board Meeting was held on September 9, 1959, at the Starmount Forest Country Club in Greensboro. Attendance was excellent, with 133 present, representing all areas of the state. The morning was taken up with business matters, including several recommendations from the Executive Committee, mainly regarding revisions to the By-Laws. The possibility of a new Mental Health project was also discussed. Dr. Roscoe D. McMillan, Chairman of our Advisory Committee, attended our meeting and was one of the Luncheon speakers. Dr. Jean Bailey Brooks, a new member of our Advisory Committee was introduced. At the Luncheon, Dr. John C. Reece, President of the Medical Society of the State of North Carolina, brought greetings. Mrs. Reece told briefly of her experiences as a Delegate at the National Convention. Dr. McMillan discussed legislation affecting the medical profession and urged all members to be alert to the dangers before us. Dr. Emery T. Kraycirik of Burlington, Chairman of the Sub-Committee on Aging of the State Medical Society, discussed the problems of the aged. Mrs. Ralph C. Lake and Mrs. John K. Wilson provided delightful entertainment during the luncheon. Following the Luncheon, the members were divided into three groups for the afternoon Workshops. Mrs. Bruce Blackmon and Mrs. Roscoe D. McMillan instructed the classes

on the money projects: A.M.E.F. and Student Loan Fund respectively. Mrs. Lacy Parsons discussed Safety, Mrs. James F. Reinhardt spoke on Community Service and Mrs. Andrew J. Crutchfield and Mrs. S. Clay Williams handled Paramedical Careers Recruitment. Thus, between the luncheon speakers and the Workshop instructors all projects of major emphasis were covered. The cover design of our GUIDE POSTS re-emphasizes our major projects. For making the Fall Board Meeting an outstanding success, my grateful thanks to Mrs. C. Henry Sikes and her able committee of Guilford County-Greensboro members.

The winter months have been busy, interesting and enjoyable, with much long-range planning, volumes of correspondence and many meetings. To date I have attended 7 District Meetings, 4 County Meetings, 4 meetings of other organizations with which we enjoy a close working relationship. It was also a privilege to attend the Medical Society Committee Conclave in Pinehurst in September, at which time I presented an outline of our year's plans before the Executive Council. The Workshop on Recruitment sponsored by the North Carolina League for Nursing was also most interesting. There are 8 more meetings definitely scheduled, and I look forward to them all. I am most grateful for the cordial hospitality shown me on all my trips.

During October I again attended the Fall Conference of Presidents and Presidents-Elect in Chicago, and once more this meeting proved to be exceedingly valuable. I participated in a panel on Paramedical Careers Recruitment with 7 other State Presidents. The program was rehearsed, but the questions up for discussion actually came from Auxiliaries all over the country. The panel was fun and it was informative. Our GUIDE POSTS received much attention, and we were asked to put it on display at the National Convention in Miami next June. Our President-Elect joined me on this trip, and we both benefited greatly. We wish to express our thanks to the Medical Society for the financial assistance given us for this important meeting.

In November I enjoyed a trip to Atlanta for the Convention of the Southern Medical Society and its Auxiliary. Our President-Elect, two past-presidents in addition to our new Councilor to Southern, attended the meeting, as well as many additional North Carolina members. The meeting was interesting and many pleasant social functions were arranged. Several scrapbooks from our North Carolina Counties were on display, as well as our GUIDE POSTS.

I have covered many miles in my travels. Planes, buses and automobiles have furnished my transportation, although on several trips a boat might have been more helpful. I have a very real regret that conflicting meetings kept me from accepting all the gracious invitations extended to me.

It is not possible in a few short pages to outline all the work done by an organization as large as ours. I wish I could give in detail the countless activities of our Auxiliary members. They have lived up to the fullest measure of our National theme of "Individual Responsibility." The scope of our work has broadened, more responsibility has been given us, and we have accepted the challenge. Reports have been received from all but 7 County Presidents, 2 Councilors and 5 Committee Chairmen. A supplemental report will be prepared before Convention, and all missing information will be included.

Membership and Organization

We have 57 Auxiliaries in which 79 of North Carolina's 100 counties are organized. This includes one Auxiliary which was inactive this year and one County which operates as two Branches. We are attempting to complete organizational work in 3 additional Counties before Convention. We have a total number of 2191 members to date, which includes 16 members-at-large and 9 Honorary Members. This represents an increase of 40 members over this time last year, and we hope to reach the magic number of 2300 members by May. The Councilors have been active, have visited their County Auxiliaries and provided guidance and inspiration to them. Districts 1 and 7 are 100% organized, although the inactive Auxiliary is in the First District. Fourteen counties report 100% membership, a record we should all try to emulate. The County Auxiliaries have worked hard in recruiting new members and retrieving the old. Coffees, teas, lunches and other social functions have been held for them.

American Medical Education Foundation

This has been one of our major projects this year. We have tried to publicize the need for contributions and conduct an educational campaign. Major emphasis was placed on A.M.E.F. at the President-Elect's Luncheon, at the Fall Board Meeting Workshop, through our Auxiliary News, and we have never relaxed our efforts. In my visits over the state, I have tried to urge our members to help with this most worthy project and persuade their husbands to increase their own donations. To date 39 Auxiliaries have contributed \$1,863.25, almost \$200 more than last year, and contributions are being received daily by the Chairman. She expects substantial donations in connection with Doctors' Day and will have a final report at the Convention. Several Auxiliaries have devoted an entire program to A.M.E.F. Our dynamic Chairman deserves tremendous credit.

Auxiliary News

The *Auxiliary News*, our quarterly publication, has been a source of information to our members as well as good reading. News of the Districts and Counties is always interesting, but mainly our capable editor has attempted to feature projects of major emphasis for the enlighten-

ment of our members. This has been done in a readable and colorful manner; pictures have added much interest to the issues. As always, we are grateful to the Hospital Savings Association of Chapel Hill for publishing our *Auxiliary News*. This year Mr. William S. Powell of The Library at the University of North Carolina, requested that we place the Library on our permanent mailing list so that all copies could be preserved. His request for all back issues of *Auxiliary News* was met to the best of our ability, although there may be some gaps.

Bulletin

This valuable National publication should be read by each officer and chairman on the State and County level. Our subscriptions have increased over last year's 41, and are now 160. Five Counties have a subscription for every member, a record I would like to cite as an example to other Counties. We need to encourage more reading of the Bulletin, which gives us so many of the answers in problems we all encounter.

By-Laws

Several changes to the By-Laws were recommended by the Executive Committee, and along with a number of previous changes, it now becomes advisable to undertake a complete revision of the By-Laws in the next two years. Several additional changes are contemplated, with special emphasis on the realignment, duties, and functions of officers. The legal department of the State Medical Society has generously agreed to assist us in preparing workable By-Laws.

Civil Defense

Thirty-nine Auxiliaries reported on Civil Defense, and most had some activity. Many of our members have taken First Aid courses, others have served as instructors. Some have worked through the schools and other organizations, and many have had general instructions in disaster preparedness. One Auxiliary has helped staff the new 200 bed Civil Defense Hospital their County has acquired. One Auxiliary placed special emphasis on seat belts; one Auxiliary discussed home shelters. Many who have not been active have at least learned the signals and have used pamphlets and posters. Interest and activity is increasing, and we are no longer complacent.

Community Health

Community Health has meant many things to many Auxiliaries. Fifteen gave *Today's Health* subscriptions to the 4-H Club King and Queen in their Counties. Some gave additional awards to these Kings and Queens. The Auxiliaries assist with all health drives in their communities, and some have special projects, such as orthopedic clinics, work on cancer surveys, cancer clinics, water fluoridation, Eye Bank, Blood typing, work with the Bloodmobile, home nursing programs, rural health projects, well-baby clinics, first aid classes, etc. One auxiliary worked with its medical society on a Diabetic Survey, another is actively sponsoring a litterbug campaign. Many

auxiliaries have supported various health agencies with cash contributions. No field pertaining to health is too small or too unimportant for our members.

Community Service

It is impossible to evaluate the full extent of Community Service in our Auxiliary. The amount of work done by individual members, either with the Auxiliary or with other organizations, staggers the imagination. There is no phase of community activity that does not find one or more Auxiliary members busy, frequently in a leadership capacity. Some Auxiliaries listed 18 or 20 organizations their members work with, and many serve as officers or on Boards. Many have originated or sponsored projects of community benefit, be it health, educational, religious, cultural or social. The Auxiliaries have made a special effort to work with retarded children, crippled children, the aged, mental patients, alcoholics, etc. They have worked with Hospital Auxiliaries, Book Carts, Toy Shops, all Health Agencies, PTA, Women's Clubs, Educational Clubs, Church organizations, and many others. One adopted a needy family at Christmas, another purchased shoes for poor children, another collected clothes for the poor. One helped furnish the new hospital lobby, another helped redecorate the Pediatric Ward at their hospital. Lamps and other accessories were given to local hospitals, doctors lounges, delivery rooms and hospital equipment was purchased. One Auxiliary has as its major project the Library in their hospital, a costly and long-range project. One Auxiliary presented an expensive movie projector to its County Library. Again, many cash donations were made to local community projects. Gifts were given to the aged by one Auxiliary at Christmas time, and a Valentine party given for them. In these, and in countless other ways, these women, our Auxiliary members, truly live up to our motto of "Service to Others."

Doctors' Day

All County Auxiliaries expect to observe Doctors' Day in some way. Some will have parties or dinners, others will send carnations to the doctors, or place flowers in hospital lobbies, others will send cards or notes. Many are planning cash donations to A.M.E.F. in honor of the doctors. Some Auxiliaries are making a special effort to honor retired doctors this year. One Auxiliary plans to make the spirit of Doctors' Day a year-round project of good public relations. Mainly, it is interesting to note that every single Auxiliary in our State plans some sort of Doctors' Day activity.

Historian

The Historian is filing a complete record of the administration of the previous President. This will prove to be more accurate, and eventually will have greater significance from the historical standpoint. The complete record of any one year's work cannot be compiled until some time

after the end of the fiscal year, and the Historian's suggestion of filing the previous year's record was gratefully adopted.

Legislation

With the Forand Bill a constant threat to organized medicine, we have made it our business to be informed on Legislation. We have used our *Auxiliary News* to pass legislative information along to our members. Our most capable Legislative Chairman has communicated with the County Auxiliaries, sent out much material, and in general kept legislative activities moving. That our Auxiliaries took legislation seriously is attested by the fact that 34 reported considerable activity and 16 devoted at least one full program to Legislation. The A.M.A. News was carefully studied; many Counties requested additional printed material for distribution among members and non-medical friends. Literally hundreds of letters voicing opposition to the Forand Bill were sent to our Congressmen. One Auxiliary sent 25 telegrams. Several used films and records, and many excellent speakers were heard. One Auxiliary saw to it that everyone voted and others promoted local bond issues. During my visits over the state, I always discussed Legislation also, and urged the members to be informed and prepared to take action. I have also written letters to the State and National Nurses Associations, expressing our disappointment in their Legislative stand, and explaining our own views. We are trying to preserve our way of life, and this fight is one we share with our husbands.

Mental Health

This is another of our major projects. A truly gratifying amount of mental health activity was reported. Twenty-seven programs were devoted to mental illness, aging, juvenile delinquency, retarded children, special education, alcoholism, etc. Films, slides and records were used by some Auxiliaries, but most of them had fine speakers. Some helped sponsor mental health clinics, others worked with retarded children in schools or in clinics, one sponsored the Laubach Method for teaching illiterates. The Auxiliaries used printed material freely, for their own information and for distribution to schools, clinics and among friends. One Auxiliary has a member who spoke at high schools. Booths at State and County Fairs were sponsored. Several groups worked with alcoholics. Patients in mental hospitals were visited. Several Auxiliaries helped in setting up child guidance clinics in schools. Several others were actually responsible for starting mental health societies; one enrolled each member in the Mental Health Society, and participation in the State Mental Health Society was urged. Substantial financial contributions were made to several County Mental Health Societies. One Auxiliary is preparing a play on "The Problems of Adolescence" which will be given by the local Little Theater Group. One Auxiliary is working toward removing obscene literature from the mails

and newsstands. Many have plans to observe Mental Health Week. Along with all this activity, we have tried to make our members practice good mental hygiene in their own lives and to promote good mental health in their families. In addition, we are preparing to present an entirely new mental health project to our membership, whereby the State Auxiliary would set up a new Endowment Fund, similar to our Sanatoria Bed Endowment Funds, but the proceeds of this new Endowment are to be used for training and research purposes in the Psychiatric Department of Memorial Hospital at Chapel Hill. The initial response to this project has been enthusiastic, and we hope to help in a concrete way in the near future. Our dedicated Mental Health Chairman deserves much credit for her tireless efforts.

Paramedical Careers Recruitment

This has been one of the most widely supported projects of the Auxiliary. Thirty-one Counties report some participation in Recruitment, with many extremely active. Our own Career Day, March 12, 1960, is being supported by most Auxiliaries, although some have had to set up a different date. Interviews have been conducted, panel discussions held, films shown and much literature distributed. One County prepared a scrapbook on health careers to be shown in the high schools. Numerous open house functions, teas, coffees and parties have been held for prospective students and student nurses. One Auxiliary is assisting in a Career-O-Rama in their County. Much guidance work has been done by Auxiliary members. Two Auxiliaries are directly responsible for organizing Future Nurses Clubs and are working on two more. Seven Auxiliaries work with existing Clubs which they helped to organize originally. One Auxiliary is assisting with a Medical Careers Club in its High School. Fifteen Auxiliaries provide scholarships for nurses and one also provides two scholarships for practical nurses. Four Auxiliaries have loan funds, all of which are being used. Two others provide spending money for student nurses, and one gives a gift to each graduating nurse in their hospital school. Money for the scholarship and loan funds is raised in many ingenious ways. It is quite apparent that over the years the County Auxiliaries have sponsored or assisted in the training of hundreds of nurses in this State, and our Paramedical Careers Recruitment program is gaining momentum. A number of Auxiliary members who are nurses have assisted in teaching and guidance programs and have manned "career booths" and provided authentic information to students. We have also enjoyed a closer relationship with the North Carolina State Nurses Association and the North Carolina League for Nursing in our Recruitment program, to the benefit of all.

Radio, TV and Movies

This medium has been used by 22 of the Auxiliaries. Many have shown movies for programs on

mental health, safety, recruitment, Eye Bank, cancer, heart, legislation, etc. Several have used radio for spot announcements, especially in connection with health drives and Doctors' Day. Our energetic Chairman has worked out a cooperative program which the Auxiliaries may use in working with their local radio stations. This mass communications medium should be used more freely, and the many excellent films available would be of benefit to members as well as the general public.

Program

The programs provided by the County Auxiliaries for the entertainment and enlightenment of their members have been varied indeed. Most of the Auxiliaries have had one or more programs on each of the projects of major emphasis, and outstanding speakers have been obtained to discuss topics of interest and importance in the field of health and of benefit to the community. Many of the Auxiliaries reported that their improved programs accounted for increased attendance at meetings, greater enthusiasm among the members, and better work. The Auxiliaries feel that they have been given real goals to strive for, and have planned programs that give the members an opportunity to work and grow together. Legislation and Mental Health headed the list of most popular program topics. The social aspect of the meetings has not been neglected, and many delightful functions were enjoyed by the members.

Research

This is a continuing project, intended to preserve historical data pertaining to doctors, medical societies, medical schools and health activities. Many of the counties have completed histories of their doctors or medical societies and are adding to these as additional information comes to light. Several new histories are under way and many biographical accounts are being written. On the State level, the project of compiling the biographies of all Past-Presidents of the State Medical Society is continuing. This is an ambitious project which will take several years to complete.

Safety

Twenty-two of the Counties reported some activity in Safety. Some have shown movies, displayed posters, others have worked with the schools, PTA groups, Scouts and civic clubs. Bicycle safety has been stressed and driver training has been promoted. One Auxiliary placed special emphasis on seat belts and urged each Auxiliary member to give a seat belt to her husband. Accident prevention has been stressed, and considerable work has been done in First Aid, and our members have served as teachers as well as students. Dangerous chemicals and poisons in the home have been discussed. Two Auxiliaries have promoted the GEMS baby sitter training program. One Auxiliary presented a delightful skit, "Your Bonnet with all the Hazards

on it" in which the members decorated hats with dangerous items commonly found in the home, and modeled the hats. Eleven Auxiliaries devoted a full program to Safety, and our members are becoming more Safety conscious.

Scrapbook

Most of the County Auxiliaries keep scrapbooks. The Counties also contribute to the State Scrapbook, and the Scrapbook Chairman displays it at the Convention each year. It makes a memorable pictorial record, and is quite a work of art. The Auxiliary has always treasured its Scrapbooks.

Sanatoria Beds

The Yoder Bed at the Gravelly Sanatorium in Chapel Hill, the last of our four endowed beds and the only one for which the \$10,000 endowment fund is not completed, has received a total of \$911.70 in contributions from 38 Auxiliaries. The returns are not all in, and we hope that by the end of the fiscal year this endowment fund will be completed. At this time only a small balance remains. During the year this bed was occupied by Mr. Robert D. Shankle, Mrs. Barbara Lucille Davis, and is at present occupied by Mrs. Gladys Lambert Gattis. The McCain Bed, which is unoccupied at present, was occupied by Miss Theresa E. Horton and Dr. James Buckman during the year. The Cooper Bed was largely idle during this past year. Mrs. Inez Taylor Mason occupied it for only a few days when her transfer became necessary. The Stevens Bed was occupied by Dr. Wesley Grimes until September and since then has been occupied by Mrs. Hazel Garner. The four Sanatoria Bed Chairmen set up a year-round Remembrance schedule, and the County Auxiliaries, at their specified time, sent gifts of money, clothing, toilet articles, books, magazine subscriptions, cards, etc. Many visits were made to the patients. Only six Counties reporting indicated that they had not observed their Remembrance Schedule, four of which stated that their bed was idle at the time. All the guests expressed appreciation of the thoughtfulness and the courtesies shown them.

Student Loan Fund

This is one of our favorite projects and one which has grown in importance over the past few years. At present 10 loans of \$500.00 each have been granted to 7 students, three of whom are receiving a loan for the maximum of two years. The Auxiliaries have given generously to the Student Loan Fund, and to date \$1,285.50 has been contributed. Recognizing the importance of helping worthy students complete their medical education, Dr. J. P. Rousseau, a former State Medical Society President and loyal friend of the Auxiliary, donated \$200.00 to the Student Loan Fund, for which we are deeply grateful. At present we have \$5,000.00 outstanding in loans. Two earlier loans have been repaid and the money reused. The student-recipients of these loans have expressed their gratitude, and Auxiliary members

share the warmth of knowing they have been helped.

S.A.M.A. and Committee on Junior Medical Families

Our three medical schools are located within the boundaries of two Auxiliaries. These groups have been very active in working with the young wives of students, interns and residents, many of whom are lonely and bewildered. One Auxiliary has made it a major project to welcome these young wives and give them a feeling of belonging. Much special attention has been given to their training as future doctors' wives—and future Auxiliary members. The student-wives of one medical school have affiliated with S.A.M.A. Social functions have been organized for these young wives, and they have been invited to attend programs and lectures. The Auxiliaries all over the state have made special efforts to include interns' and residents' wives in their activities, and many have given teas, coffees and programs for them. Some routinely invite them to their meetings. One Auxiliary included the medical wives stationed at a near-by airbase and made every effort to make them feel part of the community.

Today's Health

For the first time, this is no longer an Auxiliary project. The National Auxiliary withdrew the promotion of this fine magazine, since a new, national promotional system was to be adopted by the A.M.A. Members still maintain their interest in *Today's Health*, with many continuing their personal subscriptions. Subscriptions were presented to 4-H Club Kings and Queens by 15 Auxiliaries, and many subscriptions were presented to individuals, nurses' homes, clubs, libraries, schools and beauty parlors. One Auxiliary presented 35 subscriptions to all schools in their county, one gave 5 and several gave 2. One Auxiliary obtained 1000 copies from National headquarters in Chicago for distribution at the 1959 State Fair. Even though *Today's Health* is no longer the responsibility of the Auxiliary, a lively interest and a sense of proprietorship remains.

The Essay Contest sponsored by the Association of American Physicians and Surgeons received attention in 8 Auxiliaries. It was the major project of one Auxiliary. Promotional material was made available to all high school students who were interested, but it was felt that most high school principals did not welcome additional contests in their schools. It is possible that promotional material may be received earlier in the future so that more activity could be reported. One Auxiliary gave \$10.00 Science Awards to the best senior science students in each of its 15 high schools.

Year Books were reported by 21 Counties, and these were most helpful to their members. One County has prepared a master roster of all members as far back as they could trace, with all pertinent information given.

During the year we have tried to streamline,

simplify and standardize our work. New report forms were developed this year and some duplications have been eliminated. It is hoped that hereafter the same type of report forms can be used, without the time-consuming chore of devising new forms each year. Our stationery was redesigned this year, with a most attractive, modern letterhead. Our Auxiliary has grown so large—last year we ranked 11th in the United States—that it is necessary to think of the detail work and handle it in the most expedient manner possible. With 57 component Auxiliaries, we are one of the 5 states in the nation with more than 50 Auxiliaries. The time may come, perhaps in the not too distant future, when some outside assistance will be needed, at least during the peak periods of work. A lively and constant stream of correspondence has been conducted by your President, and it has been a pleasure to communicate with so many people, not only in our own Auxiliary, but with many other organizations and individuals. Several mimeographed mailings have been sent out, and one special letter was sent to all members-at-large in an effort to include them in the work of our Auxiliary family. Our Treasurer has done splendid work in securely reinvesting our monies so that greater interest rates will be realized. She has streamlined her own records and files, and always has all necessary information at her fingertips.

In a report such as this, it is not possible to list the wonderful, unselfish work done by many willing hearts and hands. We can touch the high spots here and there. Doctors' wives are more fortunate in many ways than their non-medical sisters, and so they have given generously of their time, talents and money. The sick, the needy, the handicapped, the lonely, the young, the old—none have been forgotten. Doctors' wives have worked industriously and intelligently in an effort to improve the communities in which they live. Much of their work remains unreported and unknown—and unrewarded, except in the hearts of those to whom helping others is a reward in itself. Newspaper coverage has been favorable in general. A few Auxiliaries have purposely avoided publicity, preferring to work quietly behind the scenes. Excellent coverage was given to our Convention and Fall Board Meeting, and we have enjoyed cordial relations with the press.

I wish to express my profound gratitude to the many who have made this year so gratifying, so pleasant, and so successful. Space would not permit listing all those to whom I am indebted, for that would mean listing virtually the entire Auxiliary roster. My special thanks go to Dr. John C. Reece, President of the State Medical Society, whose friendship, encouragement and support have meant so much; Mr. James T. Barnes and Mr. William N. Hilliard, and Mrs. Annette Boutwell, who have always been ready to assist and advise; Dr. Roscoe D. McMillan, Chairman of our Advisory Committee, who can always be count-

ed on for wise counsel, encouragement and help; the various members of the Executive Council of the Medical Society who expressed their support of our plans and projects. My thanks also go to our National officers and chairmen and to our Central Office in Chicago, not only for their help, their know-how and their cooperation, but also for the more than 5000 pieces of printed material which were sent to us free of charge. To my own wonderful officers, councilors, and committee chairmen, who worked so closely with me all through the year, and to the members of my County Auxiliary, whose loyalty and support never wavered, my heartfelt thanks. I could not close, however, without a special word of appreciation to our President-Elect, Mrs. Joseph M. Hitch and our Treasurer, Mrs. W. Ralph Deaton, Jr. Both have always been strong and dependable and a joy to work with. Mrs. Walter King, *Auxiliary News* Editor has also earned a special vote of thanks for her able and sincere cooperation. Our wonderful Past-Presidents have served not only as a source of inspiration, but often were ready with valuable and much needed advice. And let me whisper one more small "thank you"

to my own husband, whose love, understanding, patience, wisdom and occasional phenobarbital have made this year possible.

A supplemental report will be submitted and presented at the Annual Convention. The end results of the year's work may not be known for some time, however. In an organization such as ours, we stress CONTINUITY. We stress SERVICE, and we stress FRIENDSHIP. One of us starts something, and if, in the course of one short year the work cannot be completed, we have the assurance that another pair of hands will pick up the reins and continue the work. For the honor and the privilege of serving the Auxiliary as President this year, I am deeply grateful. It has been a year of labor, but a labor of love. And so I join hands with those who have gone before me and those who will follow, so that we may have an endless chain of Friendship and Service, for ultimate betterment of our fellow man.

Mrs. Robert L. Garrard
President

Greensboro, N. C.
March 1, 1960

REPORT OF THE EXECUTIVE COUNCIL

President John C. Reece, Chairman

(September 1959 to January 31, 1960)

The Executive Council met on September 27, 1959, at 10:00 A.M. in the Carolina Hotel, Pinehurst, N. C., President John C. Reece presiding. A quorum was declared present by Dr. John S. Rhodes, Secretary, following roll call to which 14 members answered present. The Council meeting was opened with invocations rendered by Dr. Rhodes in which gratitude was expressed for the life and work of Dr. William Coppridge of Durham and Past-President of the Society.

Dr. Lynwood Williams of Kinston in the Second District was recognized as Councilor elected to and first attending the Council meeting.

President Reece referred to the interest and indication for fuller liaison with the North Carolina delegates (3) to the American Medical Association and to his invitation they attend the meetings of the Executive Council—Drs. Strosnider, Hill, and Faison were so recognized.

President Reece referred to progress in organizing the committee (43) structure of the Society and its activity through these as the living expression of the Society and to the first Annual Conclave of the Committees and Commissions which he had organized and authorized to be held through the three days of September 25, 26, and 27, 1959. He proposed this procedure in the hope of increasing the effectiveness and efficiency of the Headquarters Office and the activities of the Committees. Special gratitude was expressed to the Commissioners—Drs. Wayne Benton, R. Beverly Raney, George W. Paschal, Hubert McN. Poteat, Jr., J. H. Shufford, John R. Kernodle.

On motion made, seconded and carried a special Committee was authorized by the Council to formulate a memorial expression on Dr. William Coppridge to be printed in the North Carolina Medical Journal.

The subject of House of Delegates action requesting the President to name a Committee to survey sentiment relative to the inclusion of physicians in Federal Social Security came up for discussion. The discussions still observed the position of pending legislation on the private retirement propositions of the Keogh-Simpson Bill. The subject was discussed at length and on

motion made and seconded the Executive Council authorized the President to appoint a committee to survey all aspects of the Social Security question without recommendation. On being put, the motion carried.

Reference was next made to the Armed Forces Institute of Pathology as a central registry of Pathology agencies of the Government and to the confusion of directing follow-up survey communications to persons constituting former patients of private practice reporting physicians. A motion was made that the President of the Society be authorized to write to the Armed Forces Institute of Pathology, to find if this procedure is a policy and that in the affirmative, that then a resolution be sent to the American Medical Association House of Delegates or to the Council on Medical Services stating that the Executive Council of the Medical Society of the State of North Carolina disapproves of it and would like to be on record as opposed to its continuation. The motion being seconded was put to a vote and carried.

A motion was made that this Society have a letter sent to the Governor and to the Attorney General's Office and to Dr. J. W. R. Norton as State Health Director making the point that the North Carolina Act relating to prisoner self-injury medical treatment consent is a questionable policy in the concepts of this Society and as to the feasibility of it and the possibility of its working fairly to all concerned in such treatment of self-injured prisoners. The motion was seconded, discussion ensued, and the question being put, carried.

Dr. Hubert McN. Poteat reported for the Committee on Nominations its considerations of future meeting places and of the Committee having rejected out-of-state situations, accepts the invitations of Asheville for 1961; Raleigh for 1962; and Asheville for 1963 (first week in May). On motion made duly seconded and carried the Executive Council approved this recommendation to be made to the House of Delegates by the Committee.

Moreover, the Committee on Nominations reported a sentiment within its membership to recommend the Executive Council take action to eliminate Negro membership in the Society, but it was pointed out that during 1959 the Council had considered the question and had declined to change the

the Society's position on the provisions of membership.

Dr. Hubert McN. Poteat, Jr., reported as Commissioner of Public Relations making progress references to the Committees on Hospital and Professional Relations, Medical-Legal, Legislative, Public Relations, Annual Conference of Society Officers, Rural Health, and Insurance Industry Liaison headed by Dr. Frank Jones and functioning for its first year of tenure. For the Committee on Insurance Industry he presented a document defining the duties and scope of the Committee involving nine points. On motion made, seconded and carried, the nine point document was referred to the Committee on Constitution and By-Laws for their study and recommendation.

In behalf of Dr. Charles Flowers who had requested hearing and who was ill, Dr. James Donnelly appeared and reported by request on a project fostered by the United Cerebral Palsy Foundation concerning the estimating the incidence and prevalence of Cerebral Palsy in the State of North Carolina classifying cases by type, the home situation and treatment available. Three purposes of such a survey would be: (1) improve services individuals case by case (2) develop reliable estimate of frequency of the involvement and what could be done concerning it (3) develop information concerning the epidemiological factors involved. Discussion ensued relative to physician participation in developing and releasing information similar in manner to that in the current automobile crash injury survey. However, it was observed that Cerebral Palsy incidents are being seen in 45 crippled children's clinics already and there is separate card information and classifications therein now available; so the publicity of the Foundation should be to awaken doctors to the common existence of the incidence and to the movement to do something about it, but to be guarded in professional relationships in the process. On motion made, seconded and carried the report was accepted and the plan of procedure was endorsed and support offered in carrying it out.

Dr. James Donnelly presented by request of Dr. Charles Flowers from the 1959 Report of Proceedings of the Section on Obstetrics and Gynecology an excerpt from a manuscript which he read as follows:

"Our laws should be living laws that can be adjusted to the realities of the present and the probability of the logarithmic growth of the world population. If tubal ligations are going to be performed for convenience, for socio-economic reasons, as indeed they are being performed in our State, it would seem that this operation should be

covered by the North Carolina statutes. Thus, patients who desire this procedure and physicians who employ it should use their prerogative of consulting their State Senators and Representatives, should place this problem before the Legislative Committee of our State Medical Society." Motion was made that the statement excerpted be accepted as information. The motion being seconded, discussion ensued. Upon restatement of the motion, the question was put and carried.

The Executive Council received a progress report from Mrs. Robert L. Garrad, President of the Medical Women's Auxiliary, which described in excellent detail the project work of the Auxiliary and summarized their program as entailing three major fields of interest, i.e. (1) Training of medical and allied personnel, (2) Research in mental disorders, and (3) Improved patient care, with ultimate benefit to all citizens. At the conclusion of the report there was applause. On motion made, and carried the report was accepted.

Dr. W. A. Sams reported on American Medical Association correspondence related to the acquired direct A.M.A. membership of a newly located physician in Haywood County and that the situation had been satisfactorily resolved by the physician becoming an applicant and by portal a member of the American Medical Association. On motion made, seconded, and carried the report was accepted as information.

Dr. Wayne J. Benton as Chairman of the Committee on Finance cited to the Executive Council the healthy status of the current finances of the Society which is operating within the budget for the year. He also reported a studied budget recommended to the Executive Council for the operation of the Society for the year 1960 which reflected a request for \$202,000.00 in budget accounts and a balancing revenue estimate so that the revenue prospects slightly exceeded estimates of expenditures. On motion duly made, seconded, put to a vote and carried the budget as presented was approved

MEDICAL SOCIETY OF THE STATE OF NORTH CAROLINA BUDGET ESTIMATES

January 1, 1960 to December 31, 1960

RECEIPTS: (Estimated)	\$202,590.00
Balance January 1, 1960	Nil
Assessment 2800 paying members*	140,000
Interest net (estimated on diminished quarterlies)	140
Sales (estimated on 1959)	900
Author contributions to cuts	300

Revenue unexpected (estimated) -----	1,200
Technical Exhibits (estimated on diminishment of 1959) -----	16,000
Journal Net Advertisement (estimated Local on 1959) -	4,800
Journal Net Advertisement (estimated National 1959) -	35,000
**AMA Remittances 1% of dues processed (estimated 1959) -----	650
Annual Banquet Revenue (900 @ \$4 each) -----	3,600
EXPENDITURES: (Estimated)	202,217.00
Schedule A -----	45,711
Schedule B -----	58,393
Schedule C -----	21,214
Schedule D -----	4,610
Schedule E -----	24,580
Schedule F -----	23,450
Schedule G -----	12,169
Schedule H -----	12,090

EXCESS OF RECEIPTS

OVER EXPENDITURES 373

EXCESS OF EXPENDITURES

OVER RECEIPTS Nil

RESERVES: (Estimated) ----- 50,000

BONDS: (cost value) + ----- 4,000

Increment (Series F & J Bonds)

SUBMITTED TO COMMITTEE

ON FINANCE ----- 8/16 1959

SUBMITTED TO EXECUTIVE

COUNCIL FOR APPROVAL ----- 9/27 1959

SUBMITTED TO HOUSE OF

DELEGATES FOR APPROVAL -- 5/9 1960

*Based on dues @ \$50 per member per annum

**To be appropriated to Secretarial Budget A-6

MEDICAL SOCIETY OF THE STATE OF
NORTH CAROLINA

1960 ESTIMATED BUDGET ACCOUNTS

A. EXECUTIVE BUDGET 45,711.00

A-1 President, expense of (travel and communications) ----- 2,000

A-2 Secretary, salary of ----- Nil

A-3 Secretary, travel of ----- 500

A-4 Executive Director-Treasurer, salary of ----- 11,450

A-5 Executive Director-Treasurer, travel of* ----- 3,100

A-6 Executive Office, Secretarial and Clerical Assistants** ----- 18,226

A-7 Executive Office, equipment for and/or replacements ----- 1,000

A-8 Executive Office, expense of (12 months rent, communications, printing, and supplies, repairs and replacement of expendables) - 6,400

A-9 Bonding (in effect to 19 -) ----- Nil

A-10 Audit (Quarterly & Annual) ----- 700

A-11 Taxes (salary tax) ----- 691

A-12 Insurance fire, compensation and employer's liability ----- 125

A-13 Membership Record System (addition to) ----- 48

A-14 Publications, reports and Executive aids ----- 100

A-15 Insurable: interest insurance and retirement plans ----- 1,371

*Basis: Real for personal maintenance and travel @ 7¢ per mile and/or common carrier rate and for official purposes.

**Any revenue derived from collection efforts related to American Medical Association dues and processing of same shall accrue to this item of the Budget.

B. JOURNAL BUDGET 58,393.00

B-1 Journal, publication of - 44,000

B-2 Journal, cuts for ----- 500

B-3 Editor, salary of ----- 2,310

B-4 Assistant Editor, salary of ----- 3,600

B-5 Editorial Office, expense of (12 months rent, communications, printing and supplies, repairs and replacements) ----- 400

B-6 Journal Business Manager's Office, expense of (12 months communications, printing and supplies, repairs and replacements) ----- 300

B-7 Business Manager's Office, equipment for ----- 200

B-8 Journal, travel for (Local and National) ----- 200

B-9 Taxes (salary tax) ----- 178

B-10 Refunds, subscriptions, etc. ----- 30

B-11 Roster, publication ----- 3,200

B-12 Sales tax on Journal subscriptions and Roster sales ----- 475

B-13 Transactions ----- 3,000

C. INTRA-FUNCTIONAL

ACTIVITY BUDGET 21,214.00

C-1 Executive Council, expense of and travel of Councilors including district travel ----- 2,500

C-2 Councilors, expense

	of (Communications, printing and supplies)*	100
C-3	Legislative Committee, expense of (Local and National activity)	1,000
C-1	Maternal Health Committee, expense of (secretarial, communications, printing and supplies)	2,800
C-5	Cancer Committee expense of	Nil
C-6	Convention Arrangements Committee, expense of	Nil
C-7	Scientific Exhibits Committee and Audio-Visual Program, expense of	210
C-8	Committee on Mental Health	500
C-9	Committee on Grievances	1,000
C-10	Committee on Chronic Illness	1,000
C-11	Committees in general, expense of	2,000
C-12	Committee on Anesthesia Study	300
C-13	Committee on Occupational Health	600
C-14	Committee on Professional Liability Insurance	150
C-15	Committee on Child Health	1,182
C-16	Committee on Negotiations	3,000
C-17	Committee on Student AMA (Section & Transportation)	750
C-18	Committee on Military & Emergency Medical Service	300
C-19	Committee on Industrial Commission	300
C-20	Committee on Constitution and By-Laws	1,000
C-21	Committee on Medical Credit Bureaus	500
C-22	Committee on Advisory to Department of Public Welfare	72
C-23	Committee on Medical Society Facility	750
C-24	Committee on Hospital and Professional Relations	50
C-25	Committee on Nursing	50
C-26	Committee on Medical-Legal	300
C-27	Committee on School Health	500

*Includes sums authorized by Chapter VIII, Section 2 of By-Laws.

D. EXTRA FUNCTIONAL ACTIVITIES BUDGET		4,610.00
D-1	Delegates to AMA, expense of (3 to each annual and Clinical Session)	2,700
D-2	Conference dues	200
D-3	Woman's Auxiliary (contribution to entertainment, travel to National Auxiliary for 2 and productions)	950
D-4	Delegates to AMA Regional Conferences	100
D-5	Delegate to SAMA, expense of (1 each Medical School Chapter (3))	500
D-6	A.M.E.F.	160
E. PUBLIC RELATIONS BUDGET*		21,580.00
E-1	Assistant Executive Secretary for Public Relations, salary of	9,130
E-2	Assistant Executive Secretary, travel of	1,800
E-3	Committee Chairman, out of State travel	300
E-4	Public Relations, Secretarial assistance	2,700
E-5	Public Relations, Equipment for	1,000
E-6	Public Relations Office, expense of (12 months rent, communications, printing and supplies, repairs and replacements)	3,000
E-7	Taxes (salary tax)	200
E-8	Publications and Executive aids	100
E-9	Audio-Visual depiction; photography; radio-motion picture; production, distribution and printing, purchase of films, etc.	300
E-10	Educational distributions; reprints, periodicals, press materials, pamphlets and dodgers for educational purposes; production, distribution and printing binding, stuffing and mailing	500
E-11	News and press releases, production and printing of	200
E-12	Public Relations Bulletin, production and distribution	1,800

E-13 School Physicians Conference, expense of ---	-0-
E-14 Exhibits and Displays: Purchase, rental, production, fabrication and transportation of _	650
E-15 Medical Students Conference, Annual Officers Conference ----	1,000
E-16 Physicians Press Conference -----	300
E-17 Public and personified activities in the field of Public Relations ----	800
E-18 Collateral Public Relations with other committee activities ----	500

*Authorized by action of 1949 House of Delegates with proviso that \$15 of annual dues (estimated to gross \$28,000) be specifically allocated and earmarked for support of Public Relations Program. The division allocations are estimates only and may be changed within the total of the Public Relations Budget. By later action of the Executive Council, approved by the House of Delegates, the authority to earmark any segment of member dues was eliminated.

F. ANNUAL SESSIONS (106th)	
CONVENTION BUDGET	23,450
F-1 Programs, Production of	1,700
F-2 Hotel and Auditorium expense -----	3,000
F-3 Publicity promotion, expense of (reporters and expense) -----	250
F-4 Entertainment (general involving personnel) _	800
F-5 Orchestra and floor entertainment -----	2,500
F-6 Guest Speakers (5) expense of and/or for honorarium for -----	800
F-7 Banquet Speaker, fee and expense -----	250
F-8 Electric Amplification, operators, installations and screening auditorium -----	350
F-9 Booth installations, supplies, expense, signs, (scientific and Technical) including exhibit expense and promotion -----	5,000
F-10 Projection, expense of (service rentals) ----	500
F-11 Badges (members, guests, exhibitors, auxiliary) -----	300
F-12 Reporting Service for Transactions (sessions & sections 13) -----	1,800

F-13 Rental, extra facilities, trucks for sections and /or exhibits -----	200
F-14 Exhibitors entertainment (at 5% of Exhibit Income) -----	1,100
F-15 Banquet expense and places for members remitted -----	4,400
F-16 Police Security -----	500

G. MISCELLANEOUS BUDGET	12,169.00
G-1 Previous accounts payable -----	100
G-2 Refunds (dues, etc.) ---	100
G-3 Legal Counsel, retainer fees for -----	7,500
G-4 Reporting (Executive Council, etc.) -----	1,000
G-5 President's Jewel -----	75
G-6 Token, plaque and certificates, mats and promotion of GP of year _	125
G-7 Fifty Year Club (pins and certificates for 1959) -----	100
G-8 Sections (12) expense of communication and printing -----	100
G-9 Contingency and emergency -----	750
G-10 Organizational survey implementation -----	Nil
G-11 Retirement system for Society employees ---	2,300
G-12 Advalorem Taxes (Land)	19
H. RURAL HEALTH FUNCTION	12,090.00
H-1 Committee Chairman, expense National Conference -----	300
H-2 Rural Health Consultant, salary of -----	6,006
H-3 Rural Health Consultant, travel of -----	2,000
H-4 Rural Health Function, salary, part-time secretary for -----	1,446
H-5 Salary taxes -----	188
H-6 Rural Health Conferences 1 State 6 District ----	400
H-7 Rural Health Function, office expense of (12 months communications, supplies and printing, repairs and replacements) -----	1,000
H-8 Sponsorship in favor of 4-H health activities --	400
H-9 Educational displays and distributive materials _	350

*Donations from health serving groups approv-

ed by the Executive Council may accrue to this item of the budget.

Dr. Benton referred to the powers of the Committee on Finance under the By-Laws and to the investment plans of the Committee and asked that any clarification of such expressed authority be asserted by the Council if the Committee's proposals were contrary to the provisions of the By-Laws. He stated the Finance Committee planned to invest as follows: (1) Fifty-one acres of land, which is a conservative investment on purchase of \$25,000.00 five years ago now has increased in value. \$50,000.00 in reserve funds accrued from sale of government bonds which are to be invested in the Investors Mutual Fund—an open end fund approximately composed of investments at the ratio of 70% in common stocks (for growth) and 30% in preferred stocks and bonds. This is described as not the gambling type of investment and yet not the ultra conservative—but half-way between; so that the balance ratio is about fifty-fifty should the market go bearish, "we are all right and if it goes the other way, we are all right." Dr. Benton asked approval.

Discussion ensued for clarification of information and in relation to the Society's tax position. On motion that the Executive Council approve of the action of the Finance Committee, the motion being duly seconded, the question was put to vote and carried.

Chairman Benton further referred to the "expense dollar" of the Society as follows: (1) General Administration, Executive Director's Society Headquarters, salaries, rents, taxes, etc. expenditures representing 29 per cent of the budget; Journal 29 per cent of budget; public health activities and all committees 9 per cent; legislation and public relations 12 per cent; major policy planning and execution 7 per cent; annual convention 12 per cent; and, contingencies and miscellaneous 2 per cent.

A proposition from St. Augustine College that the Society allocate funds to support a training program for speech correctionists for the public schools serving Negro pupils was presented in letter request form from its President, James A. Boyer, which request carried a total estimate of \$3,070.00. Motion was made that the communication be accepted as information. The motion was duly seconded and on being put carried.

Executive Director James Barnes reported that all Scientific Section Chairmen and those Section Secretaries responding unanimously indicated satisfaction with electrical reporting of the Sections in 1959 annual meeting of the section. However, Mr.

Barnes reported some experienced difficulty in transcribing a running report due to apparent lack of experience with participating essayists in the Sections. The Chairmen of the Council directed the discussion be regarded as information not essential to formal action.

Discussion was raised as to the status of the Relative Value Scale Study now underway. Dr. J. H. Shuford stated its purpose was a statewide application for guidance in Society negotiations in the future; that it had been designated as an Ad Hoc Committee through his action as a Commissioner as authorized by the Executive Council and delegated by President Lenox Baker, and, for the purpose of associating a group of specialists to aid and advise the Chairman. Dr. E. I. Bugg, in establishing a relative value scale of fees for schedule purposes—a three man committee responsible to the Executive Council through the office of the Chairman of the Commission on Advisory and Study and as such it would be dissolved and no longer continued once the relative value fee schedule was accepted.

General discussion ensued indicating general concept that the Ad Hoc position of the Committee met all contingencies related to its work. On motion made, duly seconded, the Relative Value Scale Study Committee was authorized to remain an Ad Hoc Committee under the Advisory and Study Commission. The motion carried.

A letter communication emanating from the President of the North Carolina Public Health Association appreciation for the sponsorship and enactment of Poliomyelitis Vaccination Act of 1959. On motion duly seconded and carried, the letter was accepted as information.

The annual request for funds from the National Society for Medical Research was considered in the light of current policy on contribution and on motion, duly seconded and carried, the request was declined.

Letter communication from the Gaston County Medical Society nominated Dr. Lowell E. Jennings of said county for State Society Honorary MEMBER related to his local standing and current medical missionary service in Rhodesia, Africa. On motion made, duly seconded, and carried, Dr. Jennings was made an Honorary Member.

A communication from the U. S. President's Commission on Employment of the Physically Handicapped came for discussion. On motion made, seconded and carried, the Committee on Public Relations was given power to act in nominating suitable, worthy and likely candidates of physicians

working in this field for recognition statewide and nationally.

Report was presented of the Hon. Thad Eure, Secretary of State, communicating Joint Resolution Number 78 enacted by the 1959 General Assembly, to wit:

"H. R. No. 705 enacted in the General Assembly. A Joint resolution commending the members of the commission to study the cause and control of cancer in North Carolina together with the North Carolina Division of the American Cancer Society, the Medical Society of North Carolina, and the State Board of Health, and providing for the continuance of this commission during the next biennium.

"WHEREAS, Governor Luther H. Hodges, pursuant to Joint Resolution No. 34 of the 1957 Session of the General Assembly, appointed the following named persons as members of the Commission to Study the Cause and Control of Cancer in North Carolina, to wit: Ozmer L. Henry, Lumberton; Dr. Rachael D. Davis, Kinston; H. Fields Young, Jr., Shelby; Mrs. H. L. Bacon, Bryson City; Mrs. Lucille Beasley, Colerain; Dr. D. H. Bridger, Bladenboro; Mrs. Alphonzo Elder, Durham; Dr. J. Grady Faulk, Monore; Dr. John R. Kernodle, Burlington; R. M. Kernon, Wilmington; Dr. Mark McD. Lindsey, Hamlet; Dr. James F. Marshall, Winston-Salem; Tom G. Maxwell, Hickory; Mrs. John C. Merrill, Jacksonville; Dr. Zack D. Owens, Elizabeth City; K. A. Pittman, Snow Hill; Dr. Hubert McN. Poteat, Jr., Smithfield; Dr. David L. Pressley, Statesville; Dr. James S. Raper, Asheville; and Mrs. Grace Taylor Rodenbough, Walnut Cove; and

"WHEREAS, this Commission has gathered valuable information and statistical records, which information has been and will be of great value to this and future Legislatures as demonstrated in its report to the Governor; and

"WHEREAS, according to its report, this Commission has been given great assistance by various boards; societies, institutes, and committees; and

"WHEREAS, the efforts of these various boards, societies, institutes, and committees will pay dividends in time to help control the number two killer—Cancer:

"NOW, THEREFORE, be it resolved by the House of Representatives, the Senate concurring:

Section 1. The Cancer Commission heretofore named is extended a hearty vote of thanks for its outstanding work on this Commission.

Section 2. The State Board of Education, the North Carolina Division of the Ameri-

can Cancer Society, the Medical Society of the State of North Carolina, particularly the Cancer Committee, the State Board of Health and the North Carolina Cancer Institute are hereby commended for their efforts to control Cancer, by education among our citizens in Cancer Control, research and operation of diagnostic centers and care of terminal cases.

Section 3. The existence of the Commission shall be continued for the effective use of assembled information and to study means of implementing their recommendations and to assist in their development, and to make such additional studies and recommendations as circumstances may warrant. The Commission to be appointed by the Governor, shall be composed of ten persons chosen from the medical profession and ten persons not associated with the medical profession. The Commission shall report to the Governor not later than January 1, 1961, its findings and recommendations, said report to be submitted by Governor to the 1961 Session of the General Assembly.

Section 4. Members of the Commission shall be paid for the performance of their duties the same per diem and subsistence and travel allowance as is provided for other Commissions in the Biennial Appropriations Act. These expenses and such other expenses as the Commission may incur in the performance of its duties, not exceeding a total of ten thousand dollars (\$10,000.00), shall be paid out of the Contingency and Emergency Fund.

Section 5. A copy of this Resolution shall be sent to the members of the Cancer Commission and to each group named.

Section 6. This Resolution shall become effective upon its adoption.

"In The General Assembly read three times and ratified, this 20th day of June, 1959.

"L. E. Barnhardt, President of the Senate and Addison Hewlett, Jr., Speaker of the House of Representatives.

Examined and found correct, Fred Holcombe, For Committee." On motion made, seconded, and carried, the Resolution was accepted as information.

The State Delegates to the American Medical Association queried the Executive Council on the frequency at which high officials of A.M.A. should be invited and urged to visit their State Society at Annual Sessions. Discussion ensued on the subject. On motion of Dr. Amos Johnson, the Delegates were instructed to seek the appearance at the Annual Sessions, at least on alternate years, of one high A.M.A. official—President, Chairman of Trustees, or Speaker of the House of Delegates, with special urgency

of invitation in the event of Dr. Julian Price's election to position of President-Elect. The motion was seconded by Dr. W. A. Sams, further discussed and upon the question being put the motion carried.

Executive Director James Barnes reported his experience in making his authorized attendance upon the Institute of Organizational Management June, 1959, and of having passed the first year of a three year course and received the certificate of Merit.

PRESIDENT REECE: There is one achievement that I want to report. The Executive Council, I think, should take official recognition of the fact that our Jim Barnes was elected President-Elect of the National Medical Society Executives Association to be elevated in June 1960. (Applause) We certainly are honored to have him elected to this position. We know his value to us in North Carolina, and we are glad that the rest of the nation has recognized his worth.

The Executive Council recessed until two o'clock.

The meeting adjourned at one o'clock.

The Executive Council meeting reconvened at two-fifteen o'clock with President Reece presiding.

Dr. James Donnelly reported for the Committee on Maternal Health of which he is Chairman. He referred to the rapidly increasing number of births estimated to reach five million for U. S. by 1960 and six million by 1970—10 years hence. He cited inferences that increases in the number of physicians will not keep pace with demands for medical service with consequent changes necessary in present management of the obstetrical patient and adequate care. His committee had reviewed the facing situation as applied to North Carolina and gained a rough analysis of projected rates of birth for the State. Specific measures were not evolved, but the Committee sensed that (1) developments should be watched closely, and (2) anticipating such increase some effort should be made to obtain better trained ancillary personnel. At a later meeting the Committee had suggested preparation of an I.B.M. deck of records which would contain physicians' name where doing deliveries, the date of birth, race, address, type of practice, the number of deliveries each does in any given year and perhaps whether they are members of the Medical Society. This record would enable rapid determination at any time of the obstetrical load per physician, which are carrying the load and some direction as to which physicians the load depended upon in the future and where teaching emphasis should be undertaken. Much of the information prevails on A.M.A.

record decks the State Society Roster, telephone directories and other sources. The decks are to be the sole property of the State Society and revelation of information would be through specific permission of the Society. Finally it was thought such uniform information would be of value to other society committees. The Committee seeks specific permission to go forward with the project of collecting and coordinating such data. Much discussion ensued. On motion, duly seconded and carried the Headquarters Office was instructed to proceed in the determination of sources of I.B.M. deck information from A.M.A., its fullness in relation to the several committee interests of the Society and some estimate of the cost of acquisition and maintenance of such a system of I.B.M. records.

Further comments of Dr. Donnelly indicated his increased employment activities to the deficiency of needed effort in the work of Maternal Health Committee Chairmanship and requested that a Secretary to the Committee without imbursement be appointed with a resident situation in the community of Winston-Salem to somewhat relieve the Chairman of the Analytical supervision. On motion, duly seconded and carried, such appointment of a Committee of Maternal Health Secretary without imbursement was authorized.

Journal Editor, Dr. Wingate Johnson, was recognized and he reported details of a July communication referred to him as Editor from Dr. Eugene Goldsmith Evans of Hendersonville protesting three editorials, to wit: United Nations, recent elections of the President of the United States and meeting in Asheville related to the Scientific Membership provisions of the Society referring to these and other editorial writings in a highly critical manner; suggesting that each editorial writer sign the editorial, proposing the fixing of individual rather than group responsibility, and, a policy expression that editorial pages do not necessarily represent the opinion of the Medical Society of the State of North Carolina. The specific request had been conveyed to the Editor that the matter be brought to the Council. Discussion ensued to indicate present Editorial Board policy and the general compliance therewith. On motion of Dr. W. A. Sams, seconded by Dr. Amos Johnson, the Council carried a vote of whole-hearted confidence in Editor Johnson and the Editorial Board.

COMMISSION REPORTS:

- A. (Note that Dr. H. M. Poteat, Jr., reported for the *Public Relations Commission* during the morning meeting

of the Executive Council.)

- B. Dr. Wayne J. Benton, *Administration Commission* referred to his earlier Finance Committee Report and the Budget both of which were adopted. He referred to the considerations of the Committee on Medical Society Headquarters Facility and the approximate even division to build and not to build on Highway 70 property at this time. It was reported as a positive action that the Committee recognized present facilities in Raleigh were inadequate and the authorization that Executive Director James Barnes to seek and rent adequate space and move the office for the time being. Moreover, the designation of a subcommittee to study the feasibility of locating the Headquarters in the future eleven miles from the limits of the City of Raleigh was reported. He strongly sensed personally that the present Committee was too large for concerted action and recommended a committee of five 1960 to 1961. A motion was made to accept the report. Discussion ensued only as to the size of the study subcommittee. The motion as made was restated, duly seconded, upon being put carried.

- C. *Advisory and Study Commission*: Dr. J. H. Shuford was recognized and he referred to the meetings of all committees under his Commission as follows:

Committee Advisory to Auxiliary and Archives of History in substance reported activities through Mrs. Robert L. Garrard's Medical Auxiliary report to the Council earlier this date. The History aspects was to be departmentally assigned for writings and elaboration to certain members as a note of progress in activity, the Chairman assuming the assignments. The Ad Hoc textbook Section made a final report and dissolved as a State Committee certain programs having been instigated at the County level to carry on through efforts of the Auxiliary on a continuing basis for the future. Moreover, the Committee on American Medical Education Fund had devised a program somewhat to be staged with continuing Auxiliary assistance of stipulated per capita goal in lieu of dues assessment undertaken in some states.

The Committee on Blue Shield reported the devising of a dental rider

in line with authorization of May actions and the initiation of that service at an early time and the completed effect of the senior certificates authorized by action in May which program is now under sale by Hospital Saving Association. Dr. Shuford reported and educational subcommittee on aspects of Blue Shield which Dr. Louis Leon Klostermyer will head with Drs. Max Rogers and Dr. John Morris associated. Finally Dr. Shuford asked instructions as to whether physician participation in the Doctor's Program might also serve as evidence of participation in the Senior Certificate program or might one participate in the latter without participating in the Doctors' Program. On motion made, seconded and carried, the Committee on Blue Shield was authorized to use its best judgment in this detail of operation.

- D. *The Committee on Constitution and By-Laws*: The principle consideration was that there had not been a printing of By-Laws since 1944 and Dr. Roscoe McMillan sensed that the By-Laws and Constitution having been broadened and brought up to date that these should be printed and bound so they would be available to members and others interested. It was recommended that these be printed at a cost of \$759.00 and distributed. On motion made and duly seconded and carried implementation of this recommendation was authorized to be put into effect studied to involve the least cost.

The recurrent problem of N. C. non-licensed government practicing physicians having society membership as residents of the State resulted in recommendation that membership requirements remain as provided in the Constitution and By-Laws, and these government employed physicians be invited as guests of local societies. This was regarded as information.

General authority was extended the Committee on Medical Credit Bureau to re-exhibit its educational display as a scientific exhibit.

- E. *Annual Convention Commission*: Dr. R. B. Raney covered the reporting for these six committees, first referring to the activities of the Committee on Arrangements for the Annual Sessions of which Secretary John S. Rhodes has served as chairman. It had held two

meetings by early fall and had recommended:

1. 1960 Sessions general timing similar to the 1959 Annual Sessions.
2. Location primarily centering around Reynolds Coliseum and N. C. State College Campus.
3. Auxiliary program generally centering at Sir Walter Hotel in downtown Raleigh.
4. Hotel Headquarters at Sir Walter Hotel.
5. Audio-visual and President's Banquet at Student Union of the N. C. State College Campus.
6. President's Ball and floor show at Coliseum.
7. Official guests to be invited: A.M.A. President, Louis Orr, A.M.A. Board of Trustees Chairman, Leonard Larson; U. S. Senator, Sam Ervin; N. C. Governor, Luther Hodges and Raleigh City Mayor, W. G. Enloe, who will address the House of Delegates on Monday.
8. Arrangements for recreational facilities for Golf, Skeet Shooting, boating, and bowling on a personal participation basis.
9. Special directional services installations and transportation facilities to coordinate the people attending to the points of activity as much as possible and practicable.

The Committee requested authorization of (1) outside sponsorship of general social hour (2) expenses of shuttle bus services down town to Reynolds Coliseum (3) additional secretarial expense incident to 1960 meeting in Raleigh. Motion was made, seconded and carried, that the Committee be authorized the permission and expense to proceed with the recommended plans.

For the Committee on Audio-Visual Scientific Postgraduate Medical Instruction the report produced a recommendation for a survey system to analyze extent of audience viewing and audience reaction to the content of the program.

For the Committee on Awards and Scientific Works report of adequate coverage of visual presentations at the 1959 Session for judging the Gaston County Award and plans for judging manuscripts for the Moore County and Wake County Awards. Reference was made to the unsatisfactory filing of

manuscripts past convention and to the compulsion under the By-Laws. It recommended system of handling manuscripts be scrutinized and improved.

For the Committee on Creditation of Delegate Credentials it was stressed that every delegate should attend every session of the House of Delegates or assign his properly authorized alternate.

For the Committee on Scientific Exhibits a preliminary allocation of 348 lineal feet of space assignments was planned.

The Committee of Golf indicated plans for a men's tournament at Raleigh Country Club and women's tournament at the Carolina Country Club with usual prizes and awards to be offered as inducements to stimulate interest.

No formal actions were taken on these reports as presented.

F. *Professional Service Commission*: Dr. George Paschal reported on this series of six committees and their activities as follows:

1. Emergency Medical Service and Military Affairs indicated that the selection services find their demands for medical personnel being met without serious difficulty of procurement. Meetings of the Committee has affected some considerations in implementing the documented and integrated medical plan in the State Civil Defense Plan. Plans for participating in alert operations have been considered and progressed. Plans for educations in the procedures of mass casualty handling is in the offing. On motion made, seconded and carried, the participation and expense of one or two members attending mass casualty instructions was authorized.

Meetings and activities of the Committee on Eye Care and Eye Bank were reported and particular reference made to the long unadjusted Commission for the Blind fee system for eye care work. It is proposed to develop a system to bill at normal service charges with notation discounting of bills to conform to established schedules with the discount characterized as charitable services. On motion made, second-

ed and carried, this recommendation on schedule for Blind Care was authorized to be effected.

The Committee on Eye Care reported progress on the Ophthalmological Section of the Relative Value Scale Study and their nomenclature and scales will be presented to the Ad Hoc Committee.

For the Committee on Insurances Chairmanned by Dr. Joseph Hooper a report of three meetings and the achievement of agreement from St. Paul Fire and Marine Insurance Company of a second ten per cent premium rate deviation on professional liability insurance as an earned position on this business done under the State Society plan. On motion, duly seconded to accept the tendered reduced rate deviation the question was put and carried.

The Committee on Insurance reported a voluntary extension of broadened benefits under the group health and accident program with Commercial Casualty Insurance Company. On motion, duly seconded and carried, the Committee was authorized to accept these improved benefit schedules.

The Committee further reported exploration of a group life insurance program but declined to recommend it for sufficient reasons.

For the Committee on Necrology has met and will continue to form of the Memorial Service, but proposed: "It is the sense of this Committee that the time of the Memorial Services be attached to and become a part of one of the two General Sessions as the Committee feels that Sunday is not the appropriate time for the Memorial Service." Discussion ensued. On motion made, seconded, and carried, the Committee was requested to continue the time of the Services as in the past and consult the Committee on Arrangements in completing details.

On motion, duly seconded and carried, the recommendation of the Committee on Postgraduate Medical Study that all efforts possible made to list every scheduled postgraduate meeting in the state about which the Society gained information.

G. *Report of Commission on Public Service*: Dr. John R. Kernodle reported on the twelve committees under this Commission and referred to the earlier report of Dr. James Donnelly for the Committee on Maternal Health and without further elaboration.

For the Committee on Anesthesia Study it was reported that said Committee desired elements of information on the I.B.M. decks about which Maternal Health had secured earlier approval of the Council. The report elaborated the training program for specialists in Anesthesiology and the loss of these to other states some what influenced of the Blue insurance programs not paying a differential for medical anesthesia work while paying a premium in instances to ancillary anesthesia personnel for similar but less competent anesthesia services.

On motion made, seconded, put to a vote and carried, the Blue Shield Committee was requested to act on this matter.

For the Committee Advisory to the Department of Public Welfare with Dr. J. S. Brewer, Chairman had considered the Harnett County Society Plan reported by Dr. Bruce Blackmon and had recommended that it be printed and dispersed to all doctors, to Superintendents of Public Welfare, County Welfare Board Chairmen and to Chairmen of County Boards of Commissioners. Also the Committee had recommended an endorsement of general assistance state appropriations to match county expenditures for medical care of indigent and medically indigent where there is not an eligibility for category assistance. Moreover, the Committee recommended adoption law information be distributed in orientation packets to new member physicians. On motion made, seconded, and carried, the recommendations cited by Dr. Kernodle for the Committee on Public Welfare were accepted.

For the Committee on Cancer reported from Dr. James Marshall, Chairman, involved three items to wit: (1) continuation of the Cancer Study Commission; (2) Request for and allocation of \$250,000 State cancer funds, (3) Continue state wide Papanicolaou smear program with cooperation of doctors; (4) approved organization of a "cured cancer congress," (5) approv-

ed the new epidemiological study of cancer by the American Cancer Society, national level survey of 10,000 N. C. families for 6 year follow period and; (6) N. C. Hospital Association plan to encourage better cancer reporting through hospital-medical records as cancer is required to be reported under N. C. Law. On motion, duly seconded, and discussed, the question of adopting the report was carried and the report adopted.

For the Committee on Child Health, of which Dr. Angus McBryde is Chairman it was reported the neonatal deaths study is progressing and in connection therewith there was a desire to have information content on the I.B.M. decks to be obtained from A.M.A. Further report indicated request for some additional funds for 1960 over the original estimates made in September 1958 due to pressing need for additional secretarial analytical effort to the extent of 50 per cent time increase. It was requested that the \$850.00 for secretarial pay set up in last year's budget be increased so that the total budget would amount to \$1,225.00 to be matched by an equal amount from the State Board of Health in 1960 and on the contingency that the Board of Health does so. On motion, duly seconded and carried, the Executive Council instructed the Committee be held to the recommended budget of the Finance Committee with the secretarial allowance of \$850.00.

For the Committee on Mental Health of which Dr. Allyn B. Choate is the Chairman, it was reported: that participation will be made in the A.M.A. Congress on Industrial Health scheduled for Charlotte, October, 1960, that the Auxiliary has been asked to consider a mental hospital bed fund favorable to physician patients yet open to research and educational use; a consideration that mental hygiene clinics be studied as to operation under the** health department which is to be further reported upon; and, that a proposed law related to crimes against nature be proposed again in the General Assembly. On motion, duly seconded and carried, the report was adopted.

For the Committee on Occupational Health chairmaned by Dr. Harry L. Johnson, a report involved the extension of the Society endorsed sponsorship of the 1960 A.M.A. Congress on

Industrial Health at Charlotte in October and to the preliminary planning the Committee has undertaken in unison with A.M.A. Council on Industrial Health necessitating an increased budget request; request that September Journal be devoted to the subject of the Congress program and its objectives; and that this Committee will also desire to exercise access and use of information on I.B.M. deck information to be sought from A.M.A. On motion made, seconded and carried, the report was adopted.

For the Committee on School Health of which Dr. Irma Henderson Smarthers is Chairman a major interest in the Governor's Youth Fitness Commission and its potential objectives was reported and the opportunity for medical leadership to give sound guidance, including determination of minimum standards for health supervision of youth. Also the determination of the Committee to conduct again the biennial school health conference in 1960 was reported, including funds for that purpose as set in the budget. On motion, duly seconded and carried, the report was adopted.

For the Committee on Veterans Affairs, so ably headed by Dr. Sam Elfmon as Chairman, problems related to contractual-intermediary agency operations were reported, particularly the VA disposition to whittle provisions out of the contract each year measures which protect the ease of effort and understanding of doctors working in the program to the extent of two thousands members. Therefore, despite 1958 authority of the House of Delegates to decline the renewal of contract, the Committee on Veterans Affairs conceded to the movement of AMA to engender more state intermediary plans on Home Town Medical Care of Veterans and did contract for a succeeding year 1959-60. On motion of Dr. W. A. Sams, duly seconded, put to a vote and carried the Committee was authorized to go forward with contract arrangements with VA as it deemed fitting.

**N. C. Hospital Board of Control in lieu of the

For the Committee on Chronic Illness, which Commissioner John R. Kernodle Chaired in addition to his Commission on Public Service, it was reported there had been two meetings since its renewal in

May; had directed staff collaboration in an A.M.A. field survey of nursing home facilities, as well as county medical society activities; reviewed objections brought from the previous year and projected others; planned area conclaves of county committee on Chronic Illness in cooperation with the county committees on legislation, blue shield and school health with some degree of continuity on chronic illness personnel at the county level, and; finally, recommendation that the Blackmon Report of Harnett County Welfare Recipient Medical Examinations Plan publication and distribution as a story of effective work at the County Society level. On motion made, duly seconded and carried, the report was accepted.

A particular report was made for the Committee on Poliomyelitis indicative of incidents of paralytic polio in non-vaccinated children and a recommendation of a communication to County Commissioners urging the provision of local funds for vaccination of children of indigent parents with stress on those over age 20 and pregnant women as constituting the high susceptible groups. Some reference to extension of the vaccination law to secondary schools, colleges and universities as compulsory in effect on entrance. The Chairman had also been instructed to communicate with industries in the local level relative to giving vaccine to their employees. On motion made, duly seconded and carried, the report was approved.

No special action taken by the Committee on Physical Rehabilitation was reported by Dr. George Holmes, except to observe that some public information should be disseminated indicating that the high per cent of welfare patients had their medical reports filled out for no charge whereas impressions are abroad that such reports are paid for to the physician. On motion, duly seconded and carried the report was approved.

The matter of Honorary Membership in favor of Dr. David Rose of Wayne County and State Senator from that District was discussed. On motion made, seconded and carried Honorary Membership for Dr. Rose was recommended to the House of Delegates.

Discussion was had relative to a Wisconsin Medical Society communication seeking endorsement of representations to the Government Post Office Department that a commemorative postage stamp dealing safe transportation be adopted. On motion made, duly seconded and carried, the Wisconsin recommendation was adopted.

To a point of discussion by the Society's

U. S. Pharmacopae Delegate, Dr. E. T. Beddingfield, on possible delegate nominations of Medical Doctors to prevailing opportunities to serve 60 divisions of U. S. P., the following nominations were suggested: Dr. David Welton, Charlotte; Dr. David A. Davis, Chapel Hill; Dr. Ernest Craig, Chapel Hill; Dr. Richard Dobson, Chapel Hill; and, Dr. Fred W. Ellis of Chapel Hill. On motion made, duly seconded and carried, these nominations to U. S. P. were accepted for recommendation.

Dr. Amos Johnson discussed the scientific aspects of the Annual Sessions Program and moved that the Executive Council authorize the Scientific Works Committee to study and report to the Council ideas and recommendations designed to alter and make more interesting the content of the General Sessions. The motion was duly seconded and long discussion ensued. Upon being put the motion carried.

The Executive Council adjourned at four forty-five o'clock.

Midyear Meeting of the Executive Council

The Executive Council met in the Crystal Room of the Carolina Hotel, Pinehurst, N. C. at ten o'clock, Sunday, January 31, 1960, with President John C. Reece presiding. Invocation was rendered by Dr. Amos N. Johnson, President-Elect, after which Secretary John S. Rhodes called the roll and fifteen members, constituting a quorum, answered present. President Reece referred to the organizing agenda and cited essential deviations in the order and procedure of the business at hand.

President Reece recognized the presence of Mr. Richard Nelson as Field Representative of the American Medical Association and called upon Dr. James P. Rousseau as Keyman National Legislative Organization to discuss national legislation. Dr. Rousseau cited the Forand Bill (HR 4700) as a dangerous and bad bill, backed by labor unions and other left-wingers and politicians seeking a vote-getting issue in a general election year; that the bill had a 50-50 chance of passage in the Second Session of the 86th Congress; and, that it was being held in Committee on Ways and Means at about the same ratio of lack of approval as it stood after hearings in the summer of 1959. He referred to 88 other bills to amend the Social Security Act designed to: modify and increase benefits, increase tax rate on income and to increase the amount of the taxable income. He recommended opposition to those designed to increase the enormous tax burden now existing and because so many have medical features affixed to them. As citizens doctors should advise Congressmen

of their views on all legislation, not just that which involves the practice of medicine. He cited needs of medical education; the various measures to develop Federal funds for their support and the weight which should be given Federal control of medical schools in the acceptance of such Federal funds. Dr. Rousseau expressed studied doubt on Congressional proposals for international medical research as scarcely supportive of real research. He referred to the long pending Keogh-Simpson-Smathers type legislation providing a system of self-employed retirement savings and investment *without current* taxation and to the proposed Smith Act on States rights in reconcilable relationship of State-Federal tax programs and urged it be supported. His study indicated no strength in the "distressed areas" bill which would lend support to "dead issue" business operations.

Dr. Rousseau as Keyman National Legislation Committee of the Society urged that officials, members, their patients and organization associates study these measures and let the Congressmen in the State know of your stand on them as on obligation of good citizenship.

Dr. James P. Rousseau also reported on his observing delegate attendance of the National Welfare Assembly, New York City, December, 1959, and the alarm which he and Dr. George Verdone of Charlotte manifested in relation to what transpired in that meeting in which health service benefits *per se* rather than dollar benefits was a salient objective with no regard to costs, standards or preservation of what is good in the present system of medical care in this nation.

At this point Mr. Richard Nelson of A.M.A. also discussed pending Federal legislation and pointed to "minimum" provisions becoming operative "maximums" under most Congressional enactments and departmental administration of these acts. He further exposed the legislative study—action program of the A.M.A. and its working aims with constituent societies. He elaborated on the status of certain proposed laws and amendments to laws pending in Congress and the analytical reasons for considering each in a favorable or unfavorable light—many health and medical measures are supported by A.M.A. and should be studied and considered in proper light in relation to individual and community interest and needs whether to support or not to support them.

Dr. Thomas R. Nichols (reporting in lieu of Dr. George Verdone who was ill) appeared reviewed a survey of chronic illnesses done by the Committee on Chronic Illness

in January 1957 through active practicing member doctors state-wide, the objective being to determine from medical loads: (1) those needing hospital care (2) those needing convalescent and (3) those for whom home care was adequate. The response-in-survey was good, but the Committee proposes a form as a device to implement a second survey to compare and proof earlier findings and to determine the Chronic disease facilities in the state. He went into some detail in explaining the form, its operation in the survey and the anticipated uses of the resulting data anticipated. He requested authority of the Executive Council for the Committee on Chronic Illness to proceed and work through the county society officers and committees. On motion, duly seconded and carried, the report was approved and the procedure authorized.

Dr. Wayne J. Benton, Chairman of the Committee on Finance, reported upon the finances of the Society, particularly referring to the audit for 1959 showing a surplus in the year's operation approximately twenty per cent of the aggregate expenditures; that only sixty per cent of the Society income is derived from dues; that forty per cent of income is derived from efforts of the Headquarters Office in the sale of advertisement, exhibit space, subscriptions and rosters, and income from investments. He reported details of expenditure accounts with some particular comments of Journal costs and revenue sources and balances related to each. Dr. Benton recommended the investment of accrued reserves for rehabilitation, at the direction the Committee on Mental Hygiene and that these be invested in Investment Mutuals, Incorporated, where other reserves have been invested. (It should be noted that said reserve is accounted in audit report as a non-cash item. ed.) On motion duly seconded and carried, the report of the Finance Committee was approved.

President Reece referred to the Council's consideration of a proposition on the Board Structure of the North Carolina Hospital Care Association of Durham relative to actions of the House of Delegates in 1958, and in this connection recognized Dr. J. Street Brewer, for long a member of the Hospital Care Association Board of Trustees, who requested that a letter emanating under a date and delivery of January 30, 1960, from B. R. Roberts, President of Hospital Care Association, and also bearing the signature of M. B. Allen as Secretary and Treasurer in which letter references were made to actions of record of the House of Delegates of the Medical Society in 1958, particularly in reference to a change in the Board structure

of the Association, among other things. The letter advised that on December 15, 1959, the Board of Hospital Care had been authorized to be changed in fulfillment of the requirements set forth by the Medical Society. The letter interpreted such change as fully according to the Association to approval as a Blue Shield Plan. Attached to the letter (under consideration) was a marked mimeographed document entitled, "By Laws of the Hospital Care Association, Incorporated, Revised as Amended December 15, 1959," and a particular or special mark at Article III, Board of Directors, Section 3, Qualifications and How Elected which read as follows: (a) Four members of the Board of Directors representing the public shall be elected by the Directors elected or appointed by the North Carolina Hospital Association and by the Medical Society of the State of North Carolina.

The first election of Directors under this subsection shall be at the quarterly meeting of Directors to be held in February 1960, at which time one director shall be elected for a term beginning the third Friday in February, 1960, and, thereafter, said election shall be held at the November quarterly meeting of the Board of Directors, but the terms of office of said four Directors representing the public shall, except as otherwise provided for the first election, commence on the third Friday in February next following the date of that election: Provided, however, that each Director heretofore elected and now serving shall remain a Director for the entire term for which he was elected, and the foregoing provisions shall be so construed as to give effect to such status: Provided, further, that in no event shall the total membership of the Board of Directors exceed twelve in number. After the reading ended at this point Dr. Brewer began discussion.

Dr. Brewer reviewed the action of the House of Delegates in 1958 which specified that everything should be on identical terms as with the Hospital Saving Association and he pointed to the contrary method of electing and the structure of the Board of Trustees of the Hospital Care Association, point of which was taken to the Executive Council September 1958, for clarification whether the method in defect in electing public representatives to the Board could be authorized, the executive had confirmed the actions of the 1958 House of Delegates. He referred to the By-Law in the record above as a fine move and a splendid opportunity for the Medical Society. Further discussion ensued as to the statement of understanding specified in the action of the House of Delegates in 1958 and Dr. Brewer stated that the

conditions of the statement of understanding prevailing for the Doctor's Program was acceptable to Hospital Care Association in 1958. President Reece indicated the matter of proceeding would be referred to the Committee on Blue Shield for implementation as authorized by the House of Delegates. Dr. Claude Squires moved that a letter be directed to the Chairman of Blue Shield Committee authorizing it to proceed. The motion was seconded and upon being put carried.

Dr. Elias Faison as AMA Delegate reported to the Executive Council that there was not a reported action of the Committee on Nursing of the AMA Board of Trustees relative to the North Carolina Resolution on Nurse Examination Test Pool and that a conclusive action could not be anticipated until after June 1960. He further indicated that AMA would not likely admit two physicians to the Test Pool Committee.

Dr. Robert Cadmus, Chairman of the Committee on nursing speaking for his committee stated: "We do feel as a point of philosophy that much of the nursing instruction is given by physicians and, secondly, that unless physicians have some supervision over the content of Nursing education, medicine loses its interest as well as its responsibility in nursing. We do not think that the nurses alone should determine what the nurses are taught, when they handle basically physician's patients; so Dr. Faison's report is quite satisfactory to our committee as an interim report. Moreover, Dr. Cadmus report his committee request that Miss Vivian Culver, Executive Secretary of the N. C. Board of Nurse Education and Registration be invited to speak to the General Sessions of the Society on details of nurse examinations and why our girls fail the "test pool" examinations. On motion made, seconded and carried, the speaking invitation was authorized to be arranged by the program committee at such form as it should determine most suitable.

On motion of Dr. Lenox Baker the Journal Editor was requested to prepare a suitable resolution relative to the recent death of Dr. Moir S. Martin then a member of the N. C. Board of Nurse Education and Registration. The motion was duly seconded and carried.

Dr. Theodore Mees made a detailed reference to the activities of his Committee, one being that of the Stanly County Hospital Staff difficulties in 1959 where the Committee communicated to the Hospital Board of Trustees considered and recommended concepts affecting hospital board, hospital administration and hospital staff operations and which culminated in the solution whereby a staff member in controversy terminated

his connections and moved from the county. Motion was made to accept the report as information. The motion was duly seconded and carried.

On motion made, duly seconded and carried, the Society's Resolution adopted in prior Sessions in opposition to the Forand Bill (HR 4700) was updated in effect.

The proposition of the N. C. Branch of the American Cancer Society to conduct in 1960 a state-wide "Cured Cancer Congress of North Carolina" was brought by Dr. Ralph Garrison for Dr. Mark Lindsay for the Committee on Cancer. On motion made, duly seconded and carried the recommendation was endorsed.

Dr. Roscoe McMillan reported for the Committee on Constitution and By-Laws revision of language for the following items: to provide a section facilitating the overlapping of membership on the respective Board of Trustees of Hospital Saving and Hospital Care Association in which it opposed interference with the House of Delegates' right to elect as it deemed proper; that the ratified action of the 1959 House of Delegates be printed in a compilation of revised Constitution and By-Laws and; to revise the By-Laws pertaining to the function and prerogatives of the Committee on Grievances.

On motion made, seconded and carried, the Executive Council approved the Committee recommendation that the Board of Trustee position on Hospital Saving And Hospital Care not be synonymous.

On motion made seconded and carried, approval was given to printing the By-Laws.

On motion made, seconded and carried, amendment of Chapter 10, Section 9, subsection "e" as recommended by the Committee on By-Laws was approved for submission to the House of Delegates to provide a procedure to expedite investigative procedure through the District Council with the consent of the accused physician.

On motion, seconded and carried, the Committee recommendation to see House adoption of amendment to provide the keeping complaints in professional confidence except providing proper information to the accused to enable preparation of answer.

A motion to approve the amendment recommendation of Chapter 10, Section 9, subsection "h" on line 8 by striking "however" and inserting after "complaint" the words "Except as above provided, will be kept confidential." The motion was seconded and was carried.

On motion to approve amendment recommendation to Chapter 10, Section 9, subsection "j" by striking the subsection and substituting language which would autho-

rize or permit the Secretary to decide investigation source as between whole committee, one or more committeemen or by the District Councilor. There was a due second, and upon being put the question carried.

On motion made, seconded and carried, the Council recommended that the principles stated in Dr. Lenox Baker's objection to Chapter 10, Section 9, subsection "w" be further considered by the Committee on Constitution & By-Laws and that it endeavor to bring to the House of Delegates suitable expression of substituting or amending language to incorporate the principles enunciated in Dr. Baker's discussion.

Chairman McMillan read a proposed new section to Chapter 10 of the By-Laws to provide: "Insurance Industry Liaison Committee." The Committee shall represent the Society concerning matters relating to the commercial insurance industry and shall maintain liaison with representative committees of the commercial insurance industry and may perform such other functions relating to commercial insurance as may be authorized or directed by the Executive Council". On motion made, seconded and carried, the Council recommends and authorizes that the above quoted section be adopted as a statement of policy and not a revision or extension of the By-Laws; therefore, this titled Committee becomes a committee of the Society appointed at the will of successive Presidents or further action of the Executive Council.

Dr. Roscoe McMillan reported for the Committee on Auxiliary and Archives of Medical History essentially as follows: An enumeration of progress in collecting segments of medical history through subcommittees related to Board of Medical Examiners, Blue Cross-Blue Shield, Radiology, Obstetrics, postgraduate work, Surgery, Auxiliary, N. C. Medical Education, public health, Medical Care Commission, general medicine and Academy of General Practice and the specific need for monies to progress the task.

On motion made, seconded and carried, the sum of Five Hundred Dollars (\$500) was authorized.

A letter communication emanating from Dr. Charles Flowers in further reference to the Executive Council of a proposal to state-wide survey the incidence of cerebral palsy and to report a defacto accomplished survey on tubal ligations performed in the State as data for use by the Committee on Legislation was on motion made, seconded and carried, received as information.

President Reece presented the request of

southeastern medical leaders regarding an entertainment of the AMA Delegates proposed by the Florida Medical Association as a joint responsibility and enterprise, which Dr. Reece sensed was an accrued social obligation of longstanding with the Society and a legitimate expenditure for the Society. Discussion ensued favoring allocation of funds as requested by the leaders to be paid to the Florida Medical Association. On motion made, seconded and carried, the sum of \$500.00 was authorized to be paid to the Florida Medical Association.

On motion made, seconded and carried, the Society Delegates to AMA were authorized to seek the establishment of AMA Convention Registration procedure by which the officers of State Medical Societies would be registered at headquarters hotel rather than at convention exhibit hall.

[The Executive Council recessed at 1:00 o'clock P.M.]

[The Executive Council reconvened at 2:15 o'clock P.M.]

The Executive Council heard a report from Dr. Bruce Blackmon of Harnett County relative to the probable development of a dispensary system by welfare agencies for drugs utilized in cases of indigency which indicated questionable health care standards involving unsound and unsafe medical treatment. On motion of Dr. Amos Johnson the report of Dr. Blackmon and the problem cited therein was made referable to the Committee on Public Relations for the purpose of making contact with representatives of health departments, representatives of mental institutions and representatives of the retail drug industry in North Carolina to work toward a proper solution of this matter. The motion was seconded, discussed, upon the question being put carried.

A concern on the part of the Committee on Cancer that reporting of cancer as required by statute was seriously lagging was presented to the Executive Council. It was apparent from discussions that there was confusion in operative administration as to responsibilities. It was stated that hospitals responsible for staff diagnostic determinations were not aware of the requirement of the Statutes. On motion the matter was referred to the Committee on Cancer with authority for it to work out a solution to making the membership of the Society aware of their obligations and duties. The motion was duly seconded and carried.

The Public Relations bulletin was authorized to carry a future item relative to encouraging the members to overcome the lag in birth and death reporting.

On motion made, seconded and carried,

the Committee on Child Health was to be notified that 1960 allocations of funds would be on the same basis as for the year 1959 and until such time as the Committee would explain its need for funds to operate during 1960.

Authority of the Executive Council to invite and preregister N. C. State College faculty members was presented by the Committee on Arrangements of the 1960 Annual Sessions. On motion made, seconded and carried, such authority was granted.

On motion made, seconded and carried, the Executive Director was authorized to determine from committees their need for specific data on decks of IBM cards proposed to be secured from AMA—the committees being Maternal Health, Occupational Health, Anesthesia Study and Chronic Illness.

On motion duly seconded and carried, the Executive Director was authorized to seek additional information in regard to the principles and administrative procedures under which the U. S. Civil Service Commission is to initiate an insurance plan of service medical coverage for civil employees of the Federal Government to be put into effect July 1, 1960.

Secretary John S. Rhodes presented for discussion a proposition from district social security officer, John Ingle, Manager, Raleigh, N. C., that an arrangement be considered whereby each of fifteen (15) district offices of social security have designated services of physicians to instruct employees about certain aspects of conditions which may result in disability on which application may be made in relation to the granting and administration of disability benefits under the social security system as provided in the bill HR-7225 enacted in 1956. Lengthy discussion ensued relative to the strengths and weaknesses of such a physician undertaking.

On motion of Dr. Chas Norfleet, seconded by Dr. Amos Johnson, the Executive Council authorized approval based on further evidence that other state societies have taken such steps, that it is an approved policy of AMA and; that the participation in the screening evaluations are in keeping with the general trend. The question being put carried.

Dr. William F. Hollister, Chairman of the Committee on Negotiations presented a progress report of the House of Delegates approval given to a legal survey and brief preparation designed to remove medical benefits from Blue Cross insurance plans in operation in the State. He stated that the Society had employed Dr. Beverly Lake, At-

torney of Raleigh to study and prepare a brief which will include all necessary aspects to be considered in the process of presenting this problem for authoritative action. In this procedure two things require the action of the Executive Council: (one) do pathologists desire to participate in these determinations and have services of their practices separated from Blue Cross; (two) the introduction of declaratory legislation in the General Assembly to provide the practice of pathology in all aspects to be the practice of medicine in North Carolina. Permission is sought for the committee to proceed through attorney with essential depositions from physicians and approach pathologists relative to clarifications thought to be essential. Motion was made that the recommendations and procedure of the Committee on Negotiations be approved. The motion was duly seconded and carried.

On motion made, seconded and carried, the secretary was instructed to poll the Past Presidents relative to their individual and collective wishes in reference to wearing the past presidents ribbon at formal occasions of the Society.

On motion, duly seconded and carried, the Executive Council decided to go into the question of supplying a designating ribbon for past secretaries of the Society.

Letters in references to complaint about former Life Membership status revised away by amendments to the Constitution and By Laws were presented to the Council. On motion seconded and carried, the letters were accepted as information.

On motion made, seconded and carried, the Secretary, Legal Counselor and Executive Director were authorized to investigate and or protest land evaluation for Wake County tax purposes as comparably excessive.

President John Reece reported that adequate spaces had been secured at headquarters present location; that renovation had been mostly at expense of building owners expense and that the space was adequate to operate there until decision to do something with the property and build a headquarters. He recommended a purchase of office chairs and furniture for conference room with improvement of esthetic qualities particularly Mr. Barne's office and headquarters office including larger desk, carpet and draperies. On motion the President and Director were authorized to workout the details of purchases and installations in the two areas. Upon being seconded the motion was put and carried.

On motion made, seconded and carried, the headquarters staff was authorized to affirm to AMA a determination of this So-

ciety to cooperate with the Law Division of AMA on legislative movements at the state level as to analytical effort and advisory resources in positions to be taken on legislation affecting medicine and the public health.

Relative to a Veterans Administration proposal to revise unliberally the Home Town Medical Care of Veterans Program contract for 1960-1961 the Council sensed the Committee on Veterans Affairs had essential authority to conclude a position for the Society. On motion made, seconded and carried, the Council authorized the Committee to report back any unforward demand which might be made of the Society in its participation.

A Query in the form of letter emanating from the N. C. Board of Medical Examiners: whether, the formation of an association of doctors for the practice of medicine, which association would not constitute a corporation under state law, but which would be classified as a corporation for Federal income tax purposes, would controvene any principle of ethics or any ethical standard or policy of the profession (of medicine) in this state and or would meet the views of the Medical Society should the Board consider obtaining a ruling from the Attorney General of North Carolina. On motion made, duly seconded and carried, the Council in view of AMA favorable resolution authorized and endorses the formation of such association for said purposes.

Letter emanating from Dr. J. R. Kernodle stated a proposal of a summer session School Health Education Work Shop by Dr. Hertz of the High Point College Faculty of High Point under which nine sponsoring agencies would participate and the indication that there should be an authorized medical representative on an Advisory Committee. On motion, duly seconded and carried, such representation was authorized.

A discussion ensued on a proposition of an admissions professional hospital staff committee to review admissions and stimulate staff members to proper scheduling and programming of their study of patients, correlating with the X-Ray Department and so on; so that patients could come in and be examined, operated and moved on quickly and, also, to encourage shortening the stay of patients avoiding unnecessary day or two on end of admission or stay. On motion, duly seconded and carried the matter was referred to the Committee on Blue Shield.

On motion, duly seconded and carried, the Council approved of a proposal that Dr. J. W. R. Norton, State Health Director to ask

the Research Triangle authorities to institute a Research Section on Cancer.

A letter of information from A. H. Robins Company, Richmond, Virginia, expressing interest in being the resource for a "community service award for physicians" was, on motion, duly seconded and carried, referred to the Committee on Public Relations.

Information was submitted that following the filing in October 1959, by St. Paul Fire and Marine Insurance Company of a ten per cent (10%) premium rate deviation, the national rating bureau of underwriter companies in the liability field filed a premium rate reduction from the previously existing state wide rate resulting in a basic policy premium of \$29.00 on general practice and some reduction on partnership and radiology.

Moreover, that St. Paul reduced its basic

policy premium rate to \$27.00 and desired to circularize the membership on this rate advantage to members. On motion made, seconded and carried, the report was accepted as information.

A motion was offered that the Executive Council approve in principle the proposition of a health institute to coordinate the activities in the State of North Carolina to take care of the Chronically ill in a home care program. The motion was duly seconded, put to vote and carried.

On motion made and approved the Executive Council adjourned at four-fifty o'clock.

Respectfully submitted
John C. Reece, M.D.
President and Chairman
Executive Council
Medical Society of the State of
North Carolina

April 25, 1960

GENERAL SESSIONS

TUESDAY MORNING SESSION

May 10, 1960

The First General Session held in connection with the One Hundred and Sixth Annual Session of The Medical Society of the State of North Carolina convened in the Reynolds Coliseum, Raleigh, North Carolina, at nine-fifteen o'clock, Dr. John S. Rhodes, Chairman of the Committee on Arrangements, calling the meeting to order.

CHAIRMAN RHODES: If this were the morning after the ball, we might have a legitimate excuse for this attendance. As it is, we have no explanation.

The Arrangements Committee, comprised of Dr. Walter Spaeth, of Elizabeth City; Dr. Millard D. Hill, of Raleigh, and myself, welcome you to this, the First General Session of the One Hundred and Sixth Annual Convention of The Medical Society of North Carolina.

It is now my pleasure to introduce the Reverend W. W. Finlater who will give the invocation.

THE REVEREND W. W. FINLATOR: Eternal God, our Father, who hast committed unto us swift and solemn trust of life, who art the healer of all diseases, and thus redeemed our lives from destruction, we bless Thee today for this gathering of men and women who follow in Thy trade of healing.

Look with favor upon the gathering here as we share our insights, as we deliberate together, as we seek to bring skill to our hands, compassion to our hearts, insight to our minds, and a sense of wonder and my-

stery to our souls, so we may bring a whole healing to the whole man. Bless us in our ministry, save us from pride of professionalism, spare us from thinking more highly of ourselves than we ought to think, lead us in the steps of the Great Physician who came not to be ministered unto but to minister. So will our ministry be rescued from the cynicism and disillusionment of the years.

And, oh God, may we not grow weary in well doing, but, whether we toil and bear the heat and burden of the day, or stand by during the lonely vigils of the night, may we find those resources of strength which only God can bring us and will teach us to endure unto the end.

Bless us, oh God, with the blessing which alone can enrich our souls and make us servants of humanity. We pray in thy great name. Amen.

CHAIRMAN RHODES: We want you to enjoy your stay in Raleigh, as well as profit by this program.

[There were various announcements.]

CHAIRMAN RHODES: It is now my real pleasure to present to you your President, Dr. John Reece. (Applause)

PRESIDENT REECE: Thank you, Mr. Secretary. The next item that I am supposed to take up right now is the recognition of distinguished guests and visitors to this convention. I think in deference to them we will give them a little time to get here. We will take that up later.

We will now proceed with the next item on the program, that is, recognition of Dr.

Bruce Blackmon for the Committee on Awards. Dr. Blackmon!

DR. BLACKMON: At this time I will recognize Dean Davison.

DEAN DAVISON: President Reece, Secretary Rhodes, and Dr. Blackmon: It is a great pleasure for me to have this opportunity of honoring one of my first colleagues, Dr. David T. Smith. Dr. Smith was doing bacteriology when I returned from the First World War in 1919. He had completed his first year of medical school, and I have since "raised him from a pup". I persuaded him to go into pediatrics, and he became a pediatric bacteriologist and then went to the Rockefeller Institute. Then he had tuberculosis and went to Raybrook, and after that he came to Duke. He was one of the original faculty as Professor of Bacteriology. In addition to his bacteriology, he had a tremendous interest in micology, and he, of course, is interested in tuberculosis which came from a personal contact with it and has been doing everything he could for the last thirty-five years to prevent tuberculosis in others.

If he will come forward I will present him with the citation for meritorious service from the President's Committee on the Employment of the Physically Handicapped.

It says "In Appreciation for exceptional contributions in advancing the employment of the physically handicapped."

DR. DAVID T. SMITH: President Reece, Dr. Davison: I certainly appreciate this award. I was born and raised in western South Carolina, but I have now lived longer in North Carolina than I ever lived in South Carolina. The warm welcome I received here when I came by the people, and and particularly by the profession, caused me to stay here, and it has been a wonderful place to work and to study, and I have always had wonderful cooperation from every doctor in the State. [Applause]

DEAN DAVISON: I think I speak for the State of North Carolina to a South Carolinian in presenting him with this award of the State of North Carolina in recognition of outstanding service in promoting the physical, social and economic well-being of the handicapped. I think he probably will value his citation even more through having received it under these circumstances than he would have if he had received it from the hands of the President, because the President is a Republican and he is a Democrat. [Applause]

DR. SMITH: I didn't know there was going to be a double award, and I have already made one speech. [Applause]

PRESIDENT REECE: We will now proceed with the program.

ceed with the program.

The next item on the program is the introduction of Dr. Keeler. The title of his address is "Immediate Exacerbation of Psychosis Upon Transfer from a Mental Hospital to a Prison." The essayist is Dr. Martin F. Keeler of the Department of Psychiatry, UNC School of Medicine, Chapel Hill. He comes from the Section on Neurology and Psychiatry.

(Dr. Keeler presented his paper.)

PRESIDENT REECE: We will proceed with our program as printed. The second subject for an address is "Observations on Etiology of Simple Goiter" by Dr. Judson J. Van Wyk of the Department of Medicine, UNC School of Medicine. It come from the Section on Internal Medicine. (Dr. Van Wyke presented his paper.)

PRESIDENT REECE: We are doing very well staying on schedule this morning, although we had a late start.

At this time I would like to recognize Dr. Tom Worth from Raleigh to present our next speaker, this paper coming from the Section on Radiology of the State Medical Society.

DR. WORTH: President Reece, Chairman Rhodes, Members of the North Carolina Medical Society and Guests: the Section on Radiology is very pleased to present our next speaker who comes to us as Director of Therapeutic Radiology, Roswell Park Memorial Institute, Buffalo, New York, Consultant in Radiation Therapy at the U. S. Veterans' Hospital in Buffalo, and Associate Clinical Professor of Radiology, University of Buffalo Medical School. It is with great pleasure that we present to you Dr. Walter T. Murphy who will speak to you on "The Meaning of Curative and Palliative Radiation."

(Dr. Murphy presented his paper.)

PRESIDENT REECE: Our next speaker certainly needs no introduction to us—his subject or his name or anything else about him. He has lived with us in North Carolina for many years. He is our own "Daddy Ross" who teaches at our University at the present time. As you know, he is from Morganton. Morganton is noted for many things, and one of the many things for which Morganton is noted is that Daddy Ross came from there, and we again welcome him. His subject is "Acute Surgical Conditions associated with Endometriosis." The paper comes from the Section on Surgery.

[Dr. Ross read his paper.]

PRESIDENT REECE: At this time I am going to ask Vice President Walton Kitchin to take over.

[Dr. Kitchin assumed the Chair.]

CHAIRMAN KITCHIN: The next item,

according to your program, is an address by Dr. Leonard W. Larson, of the Board of Trustees of the American Medical Association, who will be introduced by Dr. Reece.

PRESIDENT REECE: It is really a distinct pleasure for me to present to you this morning, Dr. Leonard Larson, Chairman of the Board of Trustees of the American Medical Association.

There are several reasons why it is a real pleasure. First, he is a fellow-pathologist, and I would like to point out that he is a pathologist that is not only a doctor. He found time to get out of his laboratory and become an outstanding medical statesman.

There is another reason why it is a real pleasure to present him this morning. He has a very strong drawing card in North Carolina, his lovely daughter and her husband, who live in Lenoir, North Carolina. They are neighbors of ours and good friends of ours. If Mr. and Mrs. John Collett are here, would you please stand and be recognized? [Applause] We are delighted that you live in North Carolina, and that you are a drawing card to bring your father and mother back here many times.

We also have Mrs. Larson with us with her daughter, Mrs. Collett. Mrs. Larson, would you stand? we would like to see you. [Applause]

There are many distinctions and things that I could tell you about Dr. Larson. But it would take up too much of our valuable time. All of us who have attended the AMA have been most impressed with the dynamic manner in which Dr. Larson has carried out his functions as Chairman of the Board of Trustees.

He is also an outstanding pathologist and has received high honors in his specialty and has been rewarded and honored by the American Cancer Association. It is really my pleasure to present to you at this time Dr. Leonard W. Larson, of Bismarck, North Dakota. Dr. Larson, we welcome you to North Carolina. We are anxious to hear you. [Applause]

(Dr. Larson presented an address.)

CHAIRMAN KITCHIN: By coincidence, or by design, our President is in a most fortuitous position to introduce the next speaker.

PRESIDENT REECE: As has been pointed out before, I live in Morganton, and it has been my home for the past fourteen years.

When I moved there right after the war to start the practice of medicine and pathology, houses were not available as they had not been built in sufficient numbers over a period of time, and it was a real problem to

find a place to live, but, we were most fortunate in that we were able to rent at that time Senator Ervin's home. He was then serving in the Congress of the United States in the House. We also inherited, with his home, the family cook, Essie, and she made life happy for all of us. One of Essie's characteristics was that she wouldn't cook on anything but the old Majestic Range, but it worked out very well, and we enjoyed her cooking. As I lived in the Senator's home, after a time I came to know him by his surroundings and to know that he was a man who was very astute in his knowledge and understanding of the vast library that he had used so well. I was also impressed with his choice of friends. He was always surrounded with things of real value.

I came to know him as a man of integrity and honesty, representing always the highest personal principles.

Since that time he has been our good friend, and we welcome him to speak to this, our General Session, today. It just says here that he has an address to give. He told me that he might have several long filibuster speeches that he could use on us today. But we are leaving that up to him. Senator Ervin, we welcome you. [Applause]

(Senator Ervin presented an address.)

PRESIDENT REECE: Thank you very much, Senator Ervin. I don't know whether you have had an opportunity to look over this audience completely or not. You said when you got here this morning you were turned over to a psychiatrist to take care of you. We have some other of your friends in the audience. At this time, I would like to recognize Colonel David L. Hardy, past Commander of the Army and Navy Legion of Valor.

COLONEL HARDY: Mr. President, Ladies and Gentlemen: It is a very great pleasure that the President has given me in allowing me three or four minutes of time on your very tight program this morning to honor our Senior Senator from North Carolina with a peculiar gift under unusual circumstances.

Our Senior Senator is a very distinguished gentleman and is a member of the Army and Navy Legion of Valor of the United States of America, which is one of the very highest honorary societies in America. He is a member of that because he is the holder of one of two very high medals. The highest honor that can be paid to a member of the Armed Forces is the award of the Medal of Honor, which is given for intrepidity over and above the usual call of duty to a member of the Armed Forces of the United States in action against the enemy.

The next highest award is the Dis-

tinguished Service Cross and its companion cross, the Navy Cross, is given under the same circumstances as is the Medal of Honor.

Senator Ervin is the holder of the Distinguished Service Cross for extraordinary heroism in action on July 18, 1918 in battle, which we know as the Battle of Soisson, in which the tide of battle of World War I turned.

But that is aside from the point. The reason that I come before you this morning is that a group of the officers met in Washington, D. C. some time ago to seek a national charter for this Army and Navy Legion of Valor, and it was put through the Congress without a dissenting vote.

So, as a token of the National organization's appreciation of Senator Ervin's very fine service, I wish to present him with this certificate of membership in the organization which I hope he will frame and put in his office, since there are only five or six other members in the entire Congress entitled to this great honor. [Applause]

SENATOR ERVIN: I want to thank Colonel Hardy for this presentation, and I want to thank my friend, John Reece, for making it possible for me to receive it on this occasion. This is an entire surprise to me.

CHAIRMAN KITCHIN: John Rhodes has failed me miserably this morning. He presented Dr. Reece earlier in the morning, and I had full expectation that he would introduce the President as well. On the other hand, an introduction of your President, John Reece, is really superfluous, and I can only say in introducing him that he is someone I think I like as much as you do. I will simply say that I like him and I commend him to you as your President. [Applause]

PRESIDENT REECE: Thank you very much.

At this time, if it is possible, before I go into this presentation of my Presidential address, I would like to recognize Dr. Frank Wilson if he is in the house at the present time. [Applause]

We all know Dr. Wilson. He is a native North Carolinian. He is Executive Vice President of the National Council on Blood and Blood Banks, and he has visited us many times in North Carolina. We are delighted to have him back this time and hope he will make it convenient to come each year.

Is Mr. Richard Nelson in the house? If so, I would like him to come forward and be recognized. [Not present.]

(President John Reece presented his Annual Address.)

CHAIRMAN KITCHIN: President Reece, we thank you for these remarks. We grateful for them. I am sure that we have all enjoyed them.

Everyone who has been on the program up to this time has come by invitation. We now have someone who has won his place on this program. We will have an address which is the presentation of the best paper selected from the Students Section meeting yesterday. The recipient and winner of this award is Charles E. Fitzgerald, Jr. of the University of North Carolina Medical School, the subject of whose paper is "Practical Bacteriology for the Private Physician."

Mr. Fitzgerald, we are extremely happy to welcome you here, and I know that our members will enjoy your paper. Our congratulations.

(Mr. Fitzgerald read his paper.)

CHAIRMAN KITCHIN: We are grateful, and I am sure you have accomplished your purpose in presenting this very fine paper which you have done so well. Are there any announcements?

If there are no announcements, we stand adjourned.

[The session adjourned at twelve-thirty o'clock.]

PRESIDENT'S DINNER

Tuesday, May 10, 1960

The President's Dinner, held in connection with the annual session of the Medical Society of the State of North Carolina was held at the College Union, State College Campus, Raleigh, North Carolina, at six-thirty o'clock, the session being called to order by Dr. John C. Reece.

PRESIDENT REECE: Ladies and Gentlemen: The Toastmaster of the evening needs no introductions to those of you who take Tuesday or Thursday afternoon off and as many weekends as possible to follow a little white ball around the golf course. When we say golf in Morganton we are talking about Billy Joe Patton. You know him too for the distinction he has achieved in his favorite game. I wish it had been possible for Billy Joe to have played with the lucky foursome during this meeting, but since that is impossible, I asked him to do something else which he is also well qualified to do, namely, to be a perfect toastmaster for any occasion.

Ladies and gentlemen, the Toastmaster of the evening, Mr. Billy Joe Patton. [Applause]

TOASTMASTER PATTON: Thank you, John.

I usually get most of my information at cocktail parties, and fortunately I was at a

nice cocktail party this afternoon and I found out really why you invited me here. It wasn't because I was a good speaker. All the folks in Morganton that are good speakers are either lawyers or fat. You didn't want the lawyers because they were all in favor of socialized medicine, and you didn't want the fat folks because it would look as though you were practicing bad medicine in Burke County. So they had a meeting, and John was not the only guilty party in this thing. They wanted to get somebody that could be toastmaster this evening that would make them look as if they were practicing good medicine around Morganton. Then they wanted to get a fellow that would say some nice things about them and they figured that I owed them so much money that I would have to say some nice things about them, although, of course, they would rather have me pay up.

Then they decided they couldn't pay an honorarium for a toastmaster, that that would just make John's Scotch blood boil. So the third reason I am here is that they had to get somebody that was free.

If you ladies and gentlemen from outside Burke County will bear with me, you will get exactly what you paid for. You are getting a free speaker. Everything connected with speaking, business, or medicine, or what have you, when it is free, is worth exactly what it costs.

(The Toastmaster preceded with a delightful conduct of the evening program.) [Applause]

(The Toastmaster recognized Dr. James P. Rousseau for the presentation of the President's Jewel.)

DR. JAMES P. ROUSSEAU: Thank you, Mr. Toastmaster. Dr. Orr, Ladies and Gentlemen and Distinguished Guests, Members and Good Friends: We now come to the happy occasion of presenting our retiring President the President's Jewel, a token of love, respect and esteem for his quite, modest leadership throughout the past year.

There are those who still feel that the success of any venture can be foretold and measured by the qualities of the individual who guides and directs its destiny. Among these qualities, most men will agree, must be ambition, foresight, ingenuity, and capacity to work. Although fate may at times take a hand, the aforementioned attributes of character must be possessed in large measure by him who will pilot an undertaking to successful conclusion. The life of our retiring President demonstrates them in almost immeasurable abundance. With him, they are everlasting and unchangeable.

Many years of close friendship and as-

sociation with him have given me the opportunity to view at close hand the great moral and spiritual force, the intelligence and clarity he has brought to bear on the problems of our Society. His year of rigorous demand has been an unusual one. However, for this gentleman, it has been the tough kind of a job on which he thrives. He has nobly performed his prime purpose of advancing the scientific and business affairs of our Society. In this quiet, modest and soft-spoken manner, he has given us the best in leadership. He will go down in the history of our Society not only as our youngest but as one of our greatest presidents.

John, it is a special privilege and genuine pleasure to present the President's Jewel to you. I am sure you will wear it with much dignity and honor. Thank you! [Applause]

DR. REECE: Thank you, Dr. Rousseau, for these very kind remarks.

I am about to become a Past President in just a few minutes, but I believe you attributed to me one honor that I do not quite possess. You said that I was the youngest president that was ever elected to the Medical Society of the State of North Carolina.

DR. ROUSSEAU: One of the youngest.

DR. REECE: I believe the honor of being the youngest actually went to Dr. Kitchin of Wake Forest. I believe he was elected President of the Medical Society when he was about one year younger than I.

I certainly appreciate what you have said. This has been a very happy year and one that has been stimulating to me and to my family, I know, because they have had to support me in a big way.

In looking back over the year, a wave of pleasant thoughts rush through my mind—numerous meetings which have brought a gratifying association with so many of you; letters of helpful suggestions, telephone conversations, and other contacts, all of which have combined to represent the strong and healthy heart-beat of a wonderful organization.

Mixed emotions accompany the arrival of this moment. There is a feeling of tremendous pride and pleasure in having been accorded the high honor of the presidency. There remains, more acutely than I expressed it a year ago, a sense of humility and unworthiness for so tremendous a responsibility, but with it a rewarding feeling from having had the privilege of helping in a small way to direct the affairs of our great Society.

In saying farewell, I do not consider my job to be over. As I step aside, I pledge to the new president, Amos Johnson, my enthusiastic support and an abiding interest

in the Medical Society of the State of North Carolina.

I am sure that you join me in giving wholehearted support to him and the new administration and that we as physicians can meet any challenge that is before us, remembering that challenge must not be minimized or brushed aside.

It is now my great pleasure to administer the oath of office of President of the Medical Society of the State of North Carolina to President-Elect, Dr. Amos N. Johnson, of Garland, North Carolina.

Amos, will you please come forward, raise your right hand, and repeat the oath after me.

[The oath of office was then repeated.]

Amos, I congratulate you upon this high honor, and the Society also for having chosen such a capable and dynamic president for next year. With firm hands such as yours at the helm, we will have a fine year under your leadership. I would like for Mrs. Johnson to stand. Ladies and gentlemen, I present to you all now your new President, your new First Lady of the Medical Society, and their attractive son, Neal. Congratulations! [Applause]

[President Amos R. Johnson addressed the Banquet Assembly.]

DR. REECE: I find now that since I have administered the oath to our new President I am really a member of a distinguished club. I look in front of me and I see all of these distinguished past presidents, the solid rocks that they are in supporting the Medical Society of the State of North Carolina against all the storms. I pledge to you again and your new administration everything that I can do in helping to provide for our people of North Carolina.

I have had many pleasures today during this convention in presenting to you distinguished guests, and now I think we have reached the top. It is an honor bestowed upon the medical profession in North Carolina to have as our distinguished speaker for the evening the President of the American Medical Association.

Ladies and gentlemen, Dr. Louis M. Orr, of Orlando, Florida, President of the American Medical Association.

(Dr. Orr presented his address.)

DR. REECE: Thank you, Dr. Orr, for bringing us this stimulating message. I assure you that we pledge to you our wholehearted association in the AMA's campaign to help preserve our freedom of medical practice.

We will now turn this back to our Toastmaster to tell us goodnight.

TOASTMASTER PATTON: It looks like Dr. Orr gave it to you pretty straight. I en-

joyed hearing you; I am on your side of the fence, Doctor.

You know, Dr. Johnson was talking about one of the fellows that helped him. I heard him adjourn a meeting one night, and if the young folks will bear with me, I will just use your Dean Wannamaker's words before we go to hear Jan Garber's Orchestra.

We hope you folks have enjoyed being here. We guests—and I am going to speak for all of them—I am sure have enjoyed this evening.

[The dinner was then adjourned to the Reynolds Coliseum where the entertainment program was conducted.]

SECOND GENERAL SESSION

Wednesday, May 11, 1960

The Second General Session convened at nine forty-five o'clock, Dr. Charles M. Norfleet, Jr., First Vice President, presiding.

CHAIRMAN NORFLEET: I would like to welcome you to the opening of the Second General Session, congratulate you on your ability, commend you on your promptness.

And it is our great pleasure to present Dr. Isa C. Grant, who is the Health Officer from the Wake County Health Department, who will speak to us on "A Follow-Up Study of Premature Infants Born in Wake County, 1949-1951—A Preliminary Report."

It gives me great pleasure to introduce Dr. Grant.

[Dr. Grant presented her paper.]

CHAIRMAN NORFLEET: Thank you so much, Dr. Grant.

It is our pleasure at this time to hear from Miss Vivian M. Culver, who is Executive Secretary of the North Carolina Board of Nurse Registration and Nurse Education in Raleigh, who will present "Some Facts about Nursing and Nursing Education in North Carolina."

(Miss Culver read her paper.)

CHAIRMAN NORFLEET: Thank you so much, Miss Culver.

This is the traditional time when the Medical Society of the State of North Carolina meets in conjoint session with the North Carolina State Board of Health. We will therefore recess the Second General Session of the Medical Society of the State of North Carolina to hold the Conjoint Session just referred to.

[The Second General Session recessed at ten o'clock.]

CONJOINT SESSION

Wednesday, May 11, 1960

The Conjoint Session of the Medical Society of the State of North Carolina and the North Carolina State Board of Health convened in the Reynolds Coliseum, Raleigh,

North Carolina, at ten-fifteen o'clock, Dr. Charles R. Bugg, of Raleigh, President of the North Carolina State Board of Health, presiding.

CHAIRMAN BUGG: Thank you very much, Dr. Norfleet.

I am going to ask the members of the State Board of Health to come up on the stage and to stand as they are called. They are: Dr. John R. Bender, Vice President; Dr. Z. L. Edwards, (Mrs. Latta is not here) Dr. Lenox Baker is not here), Dr. Roger Morrison, Dr. Earl Brian, Mr. Jasper Jackson, Dr. Ben W. Dawsey.

Now I'm going to ask Dr. Roy Norton, State Health Director, to present to the President the official detailed report of the activities of the State Board of Health.

DR. J. W. ROY NORTON: Mr. President, as has been customary, we every year make out a detailed report. This year it contains 62 pages, giving details of the work of the State Board of Health. We present that to the State Medical Society. The Comment Report, as you know, will be made by Dr. Bender.

CHAIRMAN BUGG: Dr. John R. Bender is Vice President of the State Board of Health. He has been on the Board twelve or thirteen years, he is the most experienced member, has been tremendously interested in the growth of the health program, and he is going to make a comment in regard to the year's work of the State Board of Health.

DR. BENDER: President Bugg, Dr. Morrison, Members of the Board of Health, Members of this Conjoint Session: This 62-page detailed report that you have heard Dr. Norton refer to, it falls upon me to give you the analysis of it.

I told some of them at the Board meeting this morning we would take it up item by item and discuss it line by line and then approve it all for your benefit. They didn't think so much of that, and neither did I, and I am sure neither will you. So I will go ahead with what I have here to say in a kind of brief digestive way.

[The document was presented.]

CHAIRMAN BUGG: Thank you very much, Dr. Bender. That was a very fine presentation.

The State Board of Health always has a meeting preceding this meeting, and at that meeting it passed a resolution entitled "Appreciation and a Resolution to Dr. John Hamilton." I will not read it all, but I shall read two excerpts from it.

[The excerpts were read beginning with "Dr. Hamilton came to North Carolina in 1920 as County Health Officer for New Hanover County, and in 1931 he came to the

State Board of Health, where he became Director of the Division of County Health Work and Epidemiology.

"In 1933 he became Director of the North Carolina State Laboratory of Hygiene. He has been Assistant State Health Director since 1951 and editor of *The Health Bulletin* since 1942. . . .

"In his contact with the staff and employees of the State Board of Health and with the people of North Carolina, Dr. Hamilton is first and foremost kind, understanding and considerate. His judgment and wisdom are keystones on which public health workers all over North Carolina have come to rely.

"His appearances before appropriating governing bodies in support of health programs in North Carolina have been models of accuracy, pin-pointing the salient facts of each bill, stressing economy of state money, the greatest service to the greatest number of citizens, and keeping public health in its proper perspective in relation to the total health program.

"The State Board of Health, recognizing his qualities of leadership, patience, knowledge, and kindness, thanks Dr. Hamilton for his devoted service to public health and wishes for him many years of health and happiness."

I will ask Dr. Hamilton to stand. [Applause]

This ends the Conjoint Session of the State Board of Health and the State Medical Society.

[The Conjoint Session then adjourned]

SECOND GENERAL SESSION

(Continued)

Wednesday, May 11, 1960

The Second General Session reconvened at ten-forty o'clock, Dr. Charles M. Norfleet presiding.

CHAIRMAN NORFLEET: The Second General Session is reconvened, and we give deepest thanks to the State Board of Health for their continued work—Dr. Bugg as President, Dr. Norton for his presentation of his paper, Dr. Bender for his fine presentation.

At this time, I would like to recognize Dr. Rhodes who has some announcements for us.

[Dr. Rhodes made various announcements.]

CHAIRMAN NORFLEET: Thank you, Dr. Rhodes. Infrequently a high honor comes to North Carolina in the way of recognition. We have such an honor today. Bill Waddell, who is a student at Duke University, has been elected the President-elect of the Student AMA in its convention

just preceding our convention. I would like to ask Bill to come to the rostrum and give us a few words at this time.

MR. BILL WADDELL: Thank you, Dr. Norfleet. We are indeed proud that this honor has come to us. Let me hasten to add, however, that this was due not only to the efforts of the Chapter at the University of North Carolina and Bowman Gray, but to the entire Society.

The Student AMA is a comparatively young organization, being ten years old this year. We have some 75 chapters over the country. We are a service organization, and our ideals are much the same as yours, that is, service to the medical profession, to medical education, and to the medical student.

We are extremely interested along these lines, as well as the problems of interesting young people of high school and beginning college level in careers in medicine. We believe that here is a field in which we are able to function very well.

We are proud also in this State of our close cooperation with your Medical Society. We hope one day to be a part of it, and we look forward to even more close work with you in the future. Thank you! [Applause]

CHAIRMAN NORFLEET: I am sure we all feel that the Student AMA will be in good hands, at least a year from now.

Our next speaker is the Commanding Officer of the Naval Medical Field Research Laboratory at Camp Lejeune, North Carolina. I asked him whether or not he had brought any of his staff with him and his response was, "How do you spell it?"

It is with great pleasure that we present Dr. George L. Calvy, of the Medical Corps of the United States Navy at this time, bringing to us a paper entitled "Staphylococcic Pulmonary Infections." I neglected to tell you earlier that Dr. Calvy was the recipient of the Edward Rhodes Stitt Award in 1958. [Applause]

(Dr. Calvy presented his paper.)

CHAIRMAN NORFLEET: Thank you, Captain Calvy, for this very informative paper.

You know, Dr. Johnson is a very wonderful fellow, and I congratulate you on having elected him your President. He is willing to give part of his address, give way when Commander Arnest arrives, and then finish later.

You know, a President has really two duties. One is to listen a lot, and the other is to talk considerable. We are very privileged this morning to have our newly-elected President give us a few words. Gentlemen, I present to you your President. [Applause]

PRESIDENT AMOS N. JOHNSON: Thank you, Dr. Norfleet, and thank all of you for

being here. There is a larger crowd than we usually see at these sessions, but it is getting on to the time for the presentation of prizes, and, having just been introduced, I am right now in the process of retiring for a while so that Commander Arnest, who has just arrived, can talk. What I have to say can wait. And we can get to it in just a little while.

CHAIRMAN NORFLEET: We are happy to have you come, sir. I present at this time Lt. Commander Richard T. Arnest, of the U. S. Navy, Commander of Submarine Squadron 14, Norfolk, Virginia, who will speak on "Life Aboard a Nuclear-Powered Submarine." [Applause]

(Dr. Arnest presented his address.)

CHAIRMAN NORFLEET: We are deeply grateful to you, Commander Arnest, for this very enlightening and detailed report. We hope you will not miss your plane, sir.

Our President, Dr. Johnson, was beginning to give you his message when Commander Arnest arrived. He relinquished his time so he could make the plane all right. I give you your President again. [Applause] (*PRESIDENT AMOS N. JOHNSON* presented his address.)

[The audience rose and applauded.]

CHAIRMAN NORFLEET: Many of you were not here yesterday and did not hear who your elected officers are for the coming year. I would like to ask them to stand.

First, your President-elect, Dr. Claude Squires; your First Vice President, Dr. Ted Raiford; your Second Vice President, Dr. C. T. Wilkinson; Dr. Donald Koonce was re-elected Speaker of the House, and Dr. Schoenheit Vice Speaker of the House. [Applause]

At this time I would like to ask Dr. William Nicholson to come to the rostrum, please. This is the time for the election of members to the Editorial Board of the North Carolina Medical Journal. I believe we need a little clarification. Our program says that we need to elect two members. It is my understanding that that should have been three members. I will ask Dr. Nicholson to give us a report please to clarify this.

DR. NICHOLSON: Dr. Norfleet, Ladies and Gentlemen: Before our annual meeting, to replace Dr. Hubert A. Royster, Dr. Charles Styron of Raleigh was elected to fill his unexpired term. This year there were three members of the Board whose terms expired. They were Dr. Westbrook Murphy, Dr. Wingate Johnson, and Dr. Ernest Ferguson. Our recommendation for nominations is that these men be re-elected for another term of office.

[The nominations were seconded.]

CHAIRMAN NORFLEET: Thank you,

Dr. Nicholson. You have heard the motion that these three men be reelected for another term of office. The motion has been seconded.

[There being no further nominations, the motion was put to a vote and carried.]

CHAIRMAN NORFLEET: Before declaring the adjournment of the Second General Session, I would like to ask you to remain seated since the Third General Session will immediately follow the adjournment of the Second.

[The Session adjourned at twelve forty-five o'clock.]

THIRD GENERAL SESSION

Wednesday, May 11, 1960

The Session convened at twelve forty-five o'clock, President Amos Johnson presiding.

PRESIDENT JOHNSON: I hereby declare the Third General Session of this Medical Society Meeting to be convened.

The first order of business of this Third Session is the recognition of the 50-Year Club and the presentation of the 50-Year Club certificates and pins. I would like those of you who are to receive this honor to come forward now as quickly as possible and for Dr. John Reece to make the presentation.

SECRETARY RHODES: As the names are called, the recipients will stand in front of the rostrum here in the order in which I call them, along with the person who will present the pin to them.

[The following names were called:]

Dr. George Wesley Gentry, Person County

Dr. Joseph Robert Hester, Wake County

Dr. William Lawrence Howell, Richmond County

Dr. Charles Wade McPherson, Alamance-Caswell County

Dr. Raymond Lupton Pittman, Cumberland County

Dr. Joseph Rush Shull, Mecklenburg County

Dr. Charles Franklin Strosnider, Wayne County

I believe I will read those on the list who are not here so you may know who they are:

Dr. Yates Wellington Faison, Mecklenburg County

Dr. Samuel Asberry Harding, Forsyth County

Dr. William Pinkey Herbert, Buncombe County

Dr. Robert Jones Lovill, Surry-Yadkin County

Dr. Charles Emmett Lyday, Gaston County

Dr. Hamilton Witherspoon McKay, Mecklenburg County

Dr. Richard William Spicer, Forsyth County

Dr. Charles Nichols Sprinkle, Buncombe County

Dr. Thomas W. Sumner, Henderson County

Dr. Arthur DeTalma Valk, Forsyth County

I am sure that the officers and the members of the Medical Society of the State of North Carolina join me in the happy privilege of presenting to these distinguished gentlemen and members of our Organization this evidence of their membership in the 50-Year Club, honoring them for their long and devoted service in the interest of human beings.

Fifty years is a long time to devote yourself to a single cause, and that is what these gentlemen have done whom we honor today, and we are proud to do it. Let's give them all a hand. [Applause]

When we have completed this ceremony, we will ask all of these gentlemen to step to my left in the open space so that their picture may be taken.

PRESIDENT JOHNSON: Is there any unfinished business to come before this Third Session? Is there anything that anyone would like to bring up at this time? Is there any new business to be presented?

I have no further remarks. I made my remarks a few minutes ago.

There is a reference here on the program to the report of the Nominating Committee. At this time it should be to tell us the towns to which we expect to go for the next three years with our Annual Convention. I believe that is pretty well understood. We are presently, until better facilities are available, planning to go to Asheville next year, back to Raleigh the year following. We are trying to do this scheduling for at least three years ahead. Should this Committee that is to be reactivated come up with something tenable, we would love to ask the Nominating Committee to take us back to Pinehurst where we could have our meetings as we used to. [Applause]

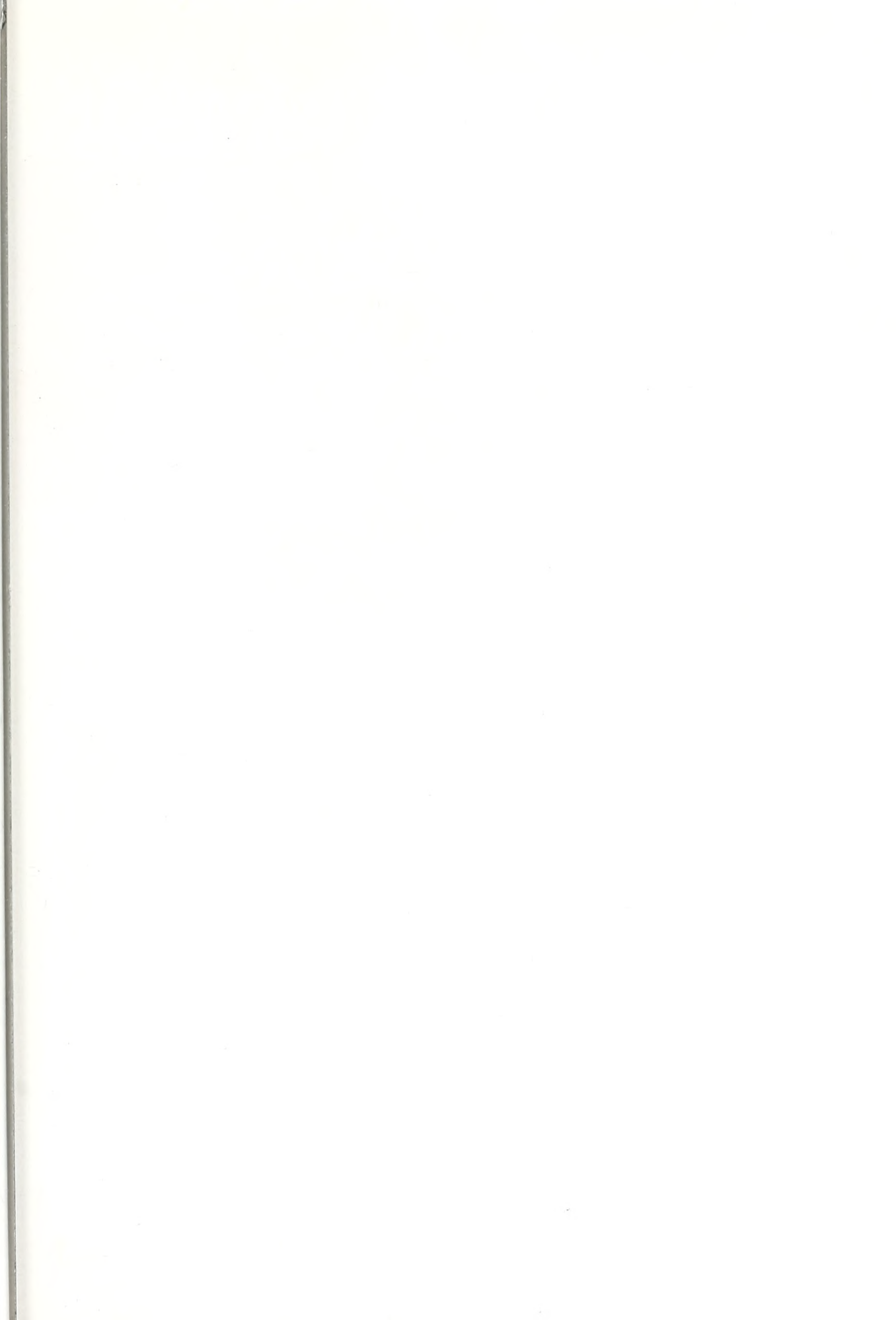
The installation of officers was handled at the Second General Session by the recognition of the officers. There is no special technique of installation of these officers.

SECRETARY RHODES: In reading the list of 50-Year Awards, I read the name of Dr. Spicer. I am informed that Dr. Richard William Spicer, of Winston-Salem, died on last Friday. I want you to know that.

PRESIDENT JOHNSON: I hereby declare this session adjourned sine die.

[The Third General Session, ending the Convention, adjourned at one fifty-five o'clock.]





NORTH CAROLINA

Medical Journal



May, 1961
Vol. 22 No. 5

IN THIS ISSUE:

Delay in the Diagnosis of Cervical Carcinoma

Robert A. Ross, M.D., and Others

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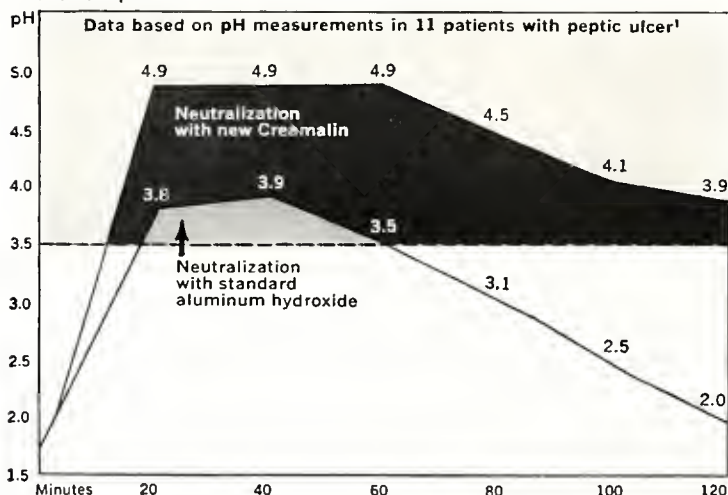
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¹ Data in the files of the Department of Medical Research, Winthrop Laboratories. ² Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: *J. Am. Pharm. A. (Scient. Ed.)* 48:384, July, 1959.

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NORTH CAROLINA MEDICAL JOURNAL

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MAY, 1961

No. 5

Delay in the Diagnosis of Carcinoma of the Cervix in North Carolina

ROBERT A. ROSS, M.D.
CHARLES E. FLOWERS, JR., M.D.
NANCY PRITCHETT, M.D.
WILLIAM H. MORRIS, JR., M.D.
and
ROBERT G. BRAME, M.D.*

CHAPEL HILL

In 1959, 204 women in North Carolina died from carcinoma of the cervix. In the past five years there have been 1,229 deaths from this form of malignancy. If there had been a similar number of deaths from polio, our newspapers would be filled with editorials and physicians would be advocating an inoculation against polio for every person who entered their office. Carcinoma of the cervix is not an infectious disease, but the use of the Papanicolaou smear can make invasive carcinoma of the cervix just as preventable a condition as poliomyelitis.

Carcinoma of the cervix is one of the few types of malignancy that can be diagnosed in its pre-invasive state. When a death certificate indicating carcinoma of the cervix as the cause of death is signed, certain questions must be asked if we are to eliminate future deaths from this disease. Did the patient err by neglecting to observe and report early symptoms of cancer? Did the physician err by not educating his patient concerning the importance of annual physical examinations, or by missing an opportunity to diagnose the disease at an earlier stage? Or was this death the result of both physician and patient error? When we begin to ask and answer these introspective ques-

tions, it will be ultimately possible to eliminate invasive cancer of the cervix.

In an effort to determine the magnitude of patient and physician delay in the diagnosis and treatment of invasive cancer and to determine possible methods of preventing this disease, a study of 203 patients at the North Carolina Memorial Hospital was made. The interviews were meticulously conducted by Drs. Pritchett and Morris and were reported in detail in their senior thesis at the University of North Carolina. The data are summarized in table 2.

Causes of Delay

Patient delay

Thirty-two and eight tenths per cent of the patients did not report abnormal bleeding because they attributed it to the "change of life." Many patients believe any abnormal bleeding in the fifth and sixth decades of life is due to the menopause, and consequently is normal. This idea is not only widely accepted by patients but also frequently by physicians. It is a common and serious misconception. Denial and fear accounted for 35 per cent of the patient delay. Ignorance of cancer and the failure of our education programs concerning this disease caused 16.1 per cent. Five and eight tenths per cent of the patients delayed reporting the symptoms of cancer because they were

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Table 1
North Carolina Deaths From Cancer of the Female Genitalia, 1955 to 1960*

Site	Year					Total
	1955	1956	1957	1958	1959	
Cervix	252	273	234	266	201	1,229
Uterus	103	107	99	126	123	558
Ovary, fallopian tube and broad ligament	107	117	102	105	132	563
Vulva and vagina	21	19	22	21	13	96
Total all sites	483	516	457	518	472	2,446

*Statistics Section, North Carolina Department of Health.

not associated with pain. An additional 6.6 per cent would not submit to a pelvic examination. There were only 5 instances in which patient delay was due to financial reasons. The other patients had spent sizeable sums on various types of medication and office visits

Physician delay

The two most common errors among physicians which caused delay in the diagnosis and treatment of carcinoma of the cervix were: (1) diagnosing the lesion as benign without performing a pelvic examination, 42.4 per cent of the cases; (2) performing the pelvic examination but not taking a smear or biopsy, 32.2 per cent. In 8 cases (13.6 per cent) a hysterectomy was performed in the presence of cancer without initially obtaining a smear and a biopsy. This is usually a fatal error, since removal of the uterus and cervix precludes adequate radiation therapy since the uterus is a receptacle for radium. Moreover, the operation enhances the spread of cancer. In 3 patients, 5.1 per cent, there was failure to perform a pelvic examination because of bleeding; in 2, failure to perform a pelvic examination during pregnancy, and in 1 patient dilatation and curettage and conization of the cervix were not performed after a suspicious smear was reported.

Another type of physician error was the initiation of empiric treatment in the presence of symptoms of cancer before establishing a diagnosis. It is imperative that the treatment of pelvic complaints be withheld

until the diagnosis of cancer has been confirmed or eliminated. To institute therapy prematurely in the presence of cancer symptoms is to give the patient a false sense of security. Pills, douches, cauterization of the cervix, vitamins and hormone injections, and treatment of urinary tract infections were some of the methods instituted in our series before the diagnosis of cancer had been made. Another serious error was the empiric use of estrogens for abnormal bleeding.

Primary factors in advanced cancer

When the 203 case histories and interviews of patients with invasive carcinoma of the cervix were critically studied it was found that in 58.6 per cent of the cases there were no symptoms during the pre-invasive phase of the disease to cause the patient to seek medical advice. We must change our emphasis, therefore, from the danger signals of cancer to the importance of periodic examinations. In 24.1 per cent of the cases there was physician error. He had had the opportunity of diagnosing the lesion at an early stage, but had failed to do so. In 17.2 per cent of the cases, the real burden of invasive cancer was upon the patient.

Methods of Reducing the Incidence of Pelvic Cancer

Interviews with these 203 patients indicated that patient education must be improved and intensified. Seventy-three patients with invasive carcinoma of the cervix could name only one of the seven dang-

Table 2
Cause of Patient and Physician Delay in 203 Cases of Invasive
Carcinoma of the Cervix in North Carolina

Reasons for Patient Delay	No.	Per Cent	Physicians' Errors	No.	Per Cent	Primary Factors for Advanced Cancer	No.	Per Cent
Believed bleeding due to "change of life"	45	32.8	Symptoms diagnosed as benign lesions without pelvic examination	25	42.4	Failure to have annual physical examination (no symptoms until cancer was advanced)	119	58.6
Denial, fear or lack of motivation	48	35.0	Pelvic examination per- formed but no smear or biopsy	19	32.2			
Ignorance of cancer	22	16.1				Physician errors (symp- toms reported immedi- ately by patient but physician delayed in making diagnosis)	49	24.1
Symptoms of cancer not associated with pain	8	5.8	Hysterectomy perform- ed in presence of cancer (no smear or biopsy)	8	13.6			
Would not submit to pelvic examination	9	6.6	Failure to perform pel- vic examination because of bleeding	3	5.1	Patient delay (symp- toms present early in course of disease but patient failed to report to a physician)	35	17.2
Inadequate finances	5	3.6	Failure to perform pel- vic examination during pregnancy	2	3.4			
			Failure to perform dila- tation, curettage and conization after suspi- cious smear	1	1.7			
			Failure to arrange hos- pitalization	1	1.7			
Totals	137	100.0		59	100.0		203	100.0

This group of 203 women contained patients with no delay, patient delay, physician delay, and patient and physician delay. All factors including time relationships were considered in determining the primary factors for advanced cancer.

er signals which have been established by the American Cancer Society; 45 per cent of these patients thought that it was impossible to have cancer without symptoms, and 54 per cent believed that the family doctor could not make the diagnosis of pelvic cancer, but that special training was necessary. An alarming finding was that 74 per cent of the patients had never heard of a cancer detection clinic, although 42 per cent were white.

Patient education can be improved by the thoughtful physician and by voluntary health organizations. Lay education concerning cancer can be improved by utilizing media to which some segments of society are frequently exposed. Some of these media are hill-billy and rock-and-roll music, sermons in rural churches, and farm and home programs. Literature on cancer can be enclosed in welfare or factory paychecks and in almanacs or state catalogues. Moreover, it is important that the material thus disseminated be presented simply and directly.

Elimination of physician delay

Physician delay in the diagnosis of cervical cancer can be reduced in four ways.

1. The physician educational program of the Cancer Committee of each county medical society can be intensified.

2. The preventability of cancer deaths can be studied and determined in a manner similar to that of the Maternal Mortality Committee. It is evident that the Maternal Mortality Committees have been eminently successful in reducing the number of maternal deaths and in providing postgraduate education in the management of obstetric difficulties.

3. The Papanicolaou smear can be more widely and properly used.

The Papanicolaou smear should be a basic part of every annual physical examination and every hospital admission. It should be just as routine as a urinalysis and a hemogram, and it would save more lives. Every female patient admitted to the out-patient department or to the hospital at the North Carolina Memorial Hospital has had a Papanicolaou smear as a part of her routine examination. This practice has made pos-

Table 3

**Summary of Data on Cancer Detection Clinic Visits in North Carolina According to Prior Visits to Private Physicians
January 1, 1953—June 30, 1955**

No. Visits to Physician	No.	Per Cent
Total number	23,628	100.0
Patients visiting their physician in last 6 months	15,405	60.1
Percentage of patients visiting physician in 12 months		79.4
Type of examination		
Complete physical examination	4,470	17.4
Breast examination	6,995	27.3
Pelvic examination	9,516	37.1
Rectal examination	6,403	25.0

During this period 3,460 patients visited their physician and requested a complete physical examination; only 1,724 or 49.8% received a physical examination which included breast, pelvic, and rectal examination.

sible the diagnosis of 23 unsuspected carcinomas in situ during 1957 and 1958 on the surgical, medical and psychiatric services. Actually, 1 case of carcinoma in situ has been found for every 218 smears taken on services other than obstetrics and gynecology. By use of the Papanicolaou smear, 70 per cent of the unsuspected carcinomas in situ have been diagnosed on services other than gynecology.

The technique is essentially available to all North Carolina physicians at the present time. Thirty-three pathologists in the state were asked how many smears they were making and could make, as well as what they thought was preventing the routine use of the smear in our state. Twenty-four (74 per cent) of the questionnaires were answered. Twenty (83 per cent) of the group felt that the lack of physician cooperation and interest was the responsible factor.

Fifty-eight and sixth tenths per cent of the 203 patients with invasive carcinoma of the cervix had no symptoms of cancer of the cervix until the disease had become advanced. Periodic examinations would have

allowed these carcinomas to be found in the pre-invasive state.

It is evident from table 3 that 79 per cent of the patients seen in cancer detection clinics in North Carolina had visited their physicians in the past 12 months, but only 17.4 per cent had received a complete physical examination; 27.3 per cent had not had an examination of the breast; 37 per cent had not had a pelvic examination; and 25 per cent had not had a rectal examination. But even more important, only 49.8 per cent of the 3,460 patients had received a complete physical examination when it was specifically requested.

The annual physical examination is not only important in cancer detection but also as a general health audit. Such an examination will lead to earlier diagnosis of diabetes, heart and renal disease, as well as psychiatric problems. It will also allow counseling in such important matters as diet, nutrition, and mental health.

Summary

1. More than 200 North Carolina women

die of cancer of the cervix each year, while 500 women acquire the disease.

2. The development of the Papanicolaou smear has made invasive carcinoma of the cervix a preventable disease.

3. There is an inordinate amount of patient and physician delay in the diagnosis and treatment of pelvic cancer. This delay can be corrected or improved by better patient education concerning the importance of the annual physical examination, and by the establishment of committees for the study of pelvic cancer in each county and city.

4. The emphasis of cancer prevention must be changed from early reporting of symptoms to the necessity of an annual physical examination and a Papanicolaou smear. Fifty-eight and six-tenths per cent of the patients with invasive cancer of the cervix had no symptoms until extensive invasion had occurred. Physician responsibility was evident in 24.1 per cent of the cases. Patients were responsible for delay in 17.2 per cent of the cases.

The phenomenal expansion of research in the past twenty years has been a strong factor in the reorientation of the roles of teaching and research in medical schools. No one in his right mind would want to retard the advancement of research, although there are plenty of instances where its quality could be improved. My only complaint is that as of now, research and teaching are out of balance, and it is time we did something about it. Hundreds of millions of dollars of public and private funds are provided each year to support research and research facilities, while only a pittance is available to medical education. We talk in grandiose terms about research programs to "wipe out cancer" or "eliminate heart disease," but who, unless we have an abundant supply of well trained physicians, is going to apply all this new knowledge for the benefit of the sick?—Lewis, H. P.: Reflections from our Mirror, *Ann. Int. Med.* 53: 1209 (Dec.) 1960.

Management of Carcinoma of the Oral Cavity

SETH G. HOBART, JR., M.D.

DURHAM

Malignant tumors of the oral cavity make up about 5 to 6 per cent of all forms of cancer occurring the human body. It is estimated that about 19,000 new cases occur annually in the United States, 80 per cent of which are in men. In 1953 there were 5,000 deaths from cancers in this site, according to the National Office of Vital Statistics. Malignant lesions within the oral cavity vary in character, clinical course, treatment, and prognosis, depending on the point of origin. Thus it becomes obvious that it is neither possible nor rational to treat them as a single group termed "cancer of the mouth."

The cure rate of oral cancers varies widely, depending upon the exact site of occurrence. Nathanson has reported that the five-year cure rates for cancer of the lip ranges from 59 to 70 per cent, as compared with only 25 per cent for cancers of other parts of the oral cavity. The degree of malignancy as indicated by histologic grade and the extent of the lesion makes for considerable variation in different reports¹.

Cancer of the lip and of the tonsils will be excluded from this discussion, which will deal with the epidermoid carcinoma limited to the oral cavity, including the buccal surfaces, the anterior two-thirds of the tongue, the posterior one-third of the tongue and the floor of the month, and carcinoma of the lower gingiva.

Etiologic Factors

Tobacco is shown to be an important causal factor, particularly in pipe and cigar smokers, but also to a lesser degree in cigarette smokers. In this area, where snuff-dipping is popular among the female working class, the practice has accounted for a number of cases that I personally have treated. Alcohol, particularly whiskey, has been shown to have a marked influence on the development of carcinoma of the oral cavity, although separating the roles of to-

bacco and alcohol is not always simple. The use of alcohol might itself have contributed to nutritional deficiencies of etiologic importance. These latter deficiencies may bear some relation to those associated with Plummer-Vincent disease—shown elsewhere to be largely responsible for the high rate of oral carcinoma in Swedish women. Poor dental hygiene has been found more commonly in cases of carcinoma, and more often in women than in men, but the direct connection remains uncertain. In the older literature, syphilis was stressed as a factor of some importance in carcinoma of the lip and of the anterior two-thirds of the tongue, but whether syphilitic glossitis or arsenicals are implicated is rather obscure².

Common Types of Oral Cancer

Leukoplakia

Leukoplakia is a precancerous lesion commonly found in the oral cavity and the lower lip. It is seen most frequently in snuff-users, persons with poor dental and oral hygiene, farmers and sailors exposed to the ultraviolet rays of solar energy in their daily occupation, and at times in persons with a large amount of dental repair utilizing metallic materials. Some workers in this field have stated that 50 to 60 per cent of all intra-oral carcinomas arise from pre-existing leukoplakic plaques. This fact is significant, and, even though not all leukoplakia of the oral cavity degenerates into carcinoma, it is the consensus that leukoplakia should be treated as a premalignant lesion and definitive therapy carried out in all cases. Treatment includes improved oral hygiene, dental care, and high vitamin A intake. Patients on this treatment should be observed regularly and persistently.

This form of therapy is advocated for diffuse, early changes. Isolated plaques of well developed leukoplakia should be locally excised and primarily closed. Pathologic studies should always be carried out. When

there is diffuse involvement of the lip by leukoplakia, the entire exposed surface may be excised readily. Cosmetic and functional results following lip shave are excellent. The procedure can very well be carried out under mental or mandibular local block anesthesia, or local infiltration of procaine may be used.

The incision is made the full length of the lip exactly along the vermilion border. The mucosa of the entire exposed surface of the lip is undermined and elevated by sharp dissection. Undermining is continued a sufficient distance beneath the mucosa on the inner side of the lip to allow the wound to be closed readily after excision of the diseased portion. After all the involved surface of the lip is removed the remaining mucous membrane is advanced and approximated to the skin edge with interrupted fine silk sutures. Hemostasis is important. In about two weeks the resurfaced lip presents an excellent cosmetic result, and the procedure has removed the precursor to an epidermoid carcinoma.

The same procedure can be carried out in massive, thick, well developed leukoplakia involving the buccal surface, and a split-thickness skin graft can be used to resurface the buccal surface. Various types of stents are used to hold the graft in place and to reconstitute the gingivobuccal sulci. It has been my experience that these grafts take readily, with less than 1 to 2 per cent loss of the graft. Again, hemostasis is important to assure success.

Epidermoid carcinoma

Most cancers of the oral cavity are epidermoid carcinomas. The grade of malignancy generally increases with involvement of the posterior oral cavity and, of course, of the pharynx³. Cancers of the anterior part of the tongue, the alveolae, and the floor of the mouth are usually of a low grade, while tumors of the tonsil, base of the tongue, and pharyngeal wall tend to be anaplastic and more aggressive in their clinical behavior. Slaughter and Southwick⁴ have described a finding which they feel is responsible for many therapeutic failures and for the ap-

pearance of separate cancers of the oral cavity. The writers term this finding "field cancerization," and it is considered a premalignant change in grossly normal-appearing mucosa around an epidermoid carcinoma of the oral cavity. The microscopic sections of the normal-appearing mucous membrane will reveal multiple foci of dyskeratosis in carcinoma in situ. This emphasizes the importance of obtaining microscopic margins on all lesions excised from the oral cavity.

Radiotherapy—Its Limitations and Uses

Both surgery and radiation play a part in the management of carcinoma of the oral cavity. Radiotherapy for this purpose has a number of limitations. It is usually contraindicated in carcinomas overlying or invading bone because of the sequelae of osteoradionecrosis. As a rule, it should not be used for recurrent carcinoma in an area previously subjected to heavy radiation. I feel that it has no place in precancerous leukoplakia, since this is often incompletely eradicated by irradiation and remains as a threat of future malignant change. Although radiotherapy may be effective in controlling primary lesions within the oral cavity, it is far less effective than surgery in the management of metastatic carcinoma in cervical lymph nodes. I have been reluctant to advise the use of irradiation in young patients in whom surgical treatment of the tumor is feasible, because of the possibility of serious late radiation changes, including postirradiation cancer of the skin and soft tissue and osteogenic sarcoma of the bone. I believe that radiotherapy should be used only in the treatment of malignant lymphomas in the area, and in the management of certain selected epidermoid carcinomas.

With the recent advance of antibiotic therapy and control of postoperative infections and the marked progress of anesthesia, radiotherapy should not be considered the treatment of choice for the more advanced carcinomas of the mouth and pharynx. Carefully administered radiation has failed to control these bulky and deeply infiltrating tumors, and has often failed even to achieve palliation. In fact, the patient's existence

may become more miserable because of the reaction to irradiation in the tumor and surrounding tissue. The more aggressive surgical attack on these larger tumors has frequently been rewarding. This is not to deny, however, that small doses of x-ray may achieve considerable palliation in some advanced and inoperable cancers by cleaning up secondary infection and reducing the bulk of the tumor mass.

Much controversy exists, even today, concerning the choice between irradiation and surgery for carcinomas in various locations of the mouth. Each case is an individual entity and differs in many respects. The treatment depends on the history of the tumor, its bulk, accessibility, and encroachment on neighboring structures, particularly bone. The commonest mistake made in some hospitals is to withhold surgery when it is indicated, and to resort to radiation because of the age or general condition of the patient. In these people, radiation therapy has a morbidity equal to and sometimes much greater than that of surgery. Again, with the bulky carcinomas, radiation has much less chance of controlling the growth than does surgery.

Surgery

The surgical removal of these bulky tumors must be three dimensional. That is, an attempt must be made to resect the primary lesion with a healthy margin of tissue in three planes. Generally, the resection must be performed in continuity with a formal bloc dissection of the lymphatic vessels and nodes on the same side of the neck.

There are several sound reasons for this approach. Cancers of the head and neck, as a rule, do not metastasize below the clavicle⁵. These tumors generally destroy life by local invasion, and the patient succumbs to the unyielding vise of cervical cancer which slowly strangulates, suffocates, and impairs cerebral blood flow. Successful surgical treatment demands aggressiveness, a thorough understanding of the involved anatomy, and an unyielding desire to remove the lesion. Such procedures are necessarily extensive and the resultant defects are sometimes large. Often nutrition

and the very airway of the patient are seriously impaired. Large portions of the mandible and tongue, even the soft tissue of the face, must sometimes be sacrificed in order to extirpate the tumor completely. The major objection to the excisional surgery of carcinomas of the oral cavity is the prevailing opinion that the patient is permanently crippled thereby, not only physically, but socially and economically as well. Reconstructive surgery has now made it possible to resect extensive lesions without fear of creating wounds which are unbearable to the patient and others.

Many have emphasized that reconstructive methods are best when combined immediately with the excision of the primary lesion and the lymphatics at the time when the exposure is optimal and before tissue contraction and psychologic deterioration have begun⁶. If the first attempt at excision fails, at least the patient is left with adequate function and comfort. Also, primary repair makes the patient more comfortable and greatly reduces the cost of hospitalization. It also returns him to society much earlier. Wound complications, pulmonary infections, and disturbances in breathing and alimentation are reduced to a minimum. These wounds are contaminated by oral organisms, the local blood supply is often embarrassed, and conditions for wound healing are not ideal. Thus, if cervical metastasis is present, the extremely high rate of local recurrence is such that reconstruction probably should be delayed in the vast majority of cases until there is reasonable evidence that the disease has been controlled⁷.

In the past, cautery has been used extensively for the destruction of intraoral carcinoma. Its use is always followed by delayed healing, discomfort, infection, and often extensive scarring and distortion of tissues. This technique has little place in the present day management of these tumors. Excision by sharp dissection, followed by careful wound repair, accomplishes more adequate control of the neoplasm and more satisfactory recovery of function. Lesions in the anterior portion of the oral cavity usually may be excised

through the open mouth. Inaccessible lesions require exposure by dividing the lower lip and skin of the chin in midline, thus forming a flap. Occasionally the body of the mandible must be divided and retracted for access to the lesions at the base of the tongue and in the pharynx.

The following cases illustrate the various surgical procedures used to control malignancy of the oral cavity:

Case 1

This patient had diffuse leukoplakia involving the lower lip, with a small, 4 mm. ulcer on the right vermilion border overlying the plaque. Epidermoid carcinoma of the lip is frequently associated with diffuse leukoplakia. When the carcinoma is this small, it may be treated by simple V excision with simultaneous removal of the remaining leukoplakia by lip shave. When the cancer is of sufficient size to require more extensive excision and plastic repair, it is best to defer excision of any co-existing areas of leukoplakia.

Case 2

In this patient a low grade epidermoid carcinoma involving the lower gingiva and adjacent floor of the mouth was excised locally. The lesion had not invaded bone or metastasized to the cervical lymph nodes. More advanced lesions would require the combined operative procedure, including resection of the mandible and radical neck dissection. It is well to bear in mind that invasion of bone is not always demonstrated by x-ray. Therefore, any lesion that is firmly fixed to bone or ulcerating in the bone should be considered as invading the bone, and is not suitable for local excision. This patient was treated by local wide excision involving the removal of all tissue down to the geniohyoid muscle, with complete disregard for the orifices of Wharton's ducts. Included in this bloc of tissue was the upper surface of the alveolar process of the mandible. Primary closure was effected by approximating the mucosa of the floor of the mouth to that of the gingivolabial sulcus across the exposed segment of the mandible. Larger defects require coverage with a split-thickness skin graft applied directly to the bone and held in place with a stent of gauze and molded dental wax.

Case 3

A rather large, but low grade epidermoid carcinoma at the base of the tongue was seen in a chronic alcoholic who presented the chief complaint of "sore throat." Histologic examination proved this to be a rather low grade epidermoid

carcinoma. Palpation of the neck revealed questionable nodes of the submaxillary triangle. Decision to treat this lesion by surgery was reached, since it was felt that neck dissection should be performed.

Treatment of carcinomas at the base of the tongue and soft palate and tonsillar regions surgically should always include neck dissection since adequate exposure of these sites requires division and often excision of the mandible. In this case, it was not necessary to remove the mandible; it was divided, however, for exposure. A complete neck dissection was performed and a cheek flap was raised by dividing the lower lip and incising the gingivobuccal gutter as far as the retromolar region. The mandible was then divided with a Gigli saw well anterior to the site of the tumor. Next the tongue was retracted forward by a suture and retraction of the ends of the mandible, giving adequate exposure to the base of the tongue. The tumor was then excised with a wide margin of normal mucosa and underlying muscle. The defect was then closed with interrupted chromic catgut sutures and the mandibular fragments reapproximated and stabilized with a Kirschner wire drilled across the fracture site or wired with ≈ 0.020 Baker wire. Closure of the gingivobuccal gutter was accomplished with interrupted sutures of fine silk. More extensive lesions at the base of the tongue require wider excisions, necessitating portions of the lateropharyngeal wall and soft palate, and partial mandibulectomy.

Case 4

A 60 year old truck driver was referred by his dentist after some weeks of treatment of an alveolar lesion. He had undergone extraction of a molar tooth, lower left, some eight weeks previously. The defect failed to heal following the extraction, in spite of ointments, irrigation and curettage. At the time of referral the patient had a 3 cm., hard, fixed mass at the outer aspect of the mandible and shotty nodes, some of which were tender, within the submaxillary space, and one rather hard node of the deep cervical chain at the bifurcation of the carotid artery. Histologic examination revealed an epidermoid carcinoma. Excision combined with resection of the mandible is the treatment of choice for this lesion. This combined procedure is also generally chosen for treatment of typical carcinoma of the floor of the mouth with invasion of the body of the mandible. Radical neck dissection was performed in the usual manner, except that the digastric triangle was not cleared superiorly. The contents of the neck remained attached to the lower border of the mandible and the submaxillary gland. The lower lip was split in mid-line and the cheek flap elevated by incision along the gingivobuccal gutter, leaving an ample margin of normal tissue around the involved area of the

mandible. The mandible was then divided well anteriorly with the Gigli saw and posteriorly disarticulated at the temporomandibular joint.

In this case an intra-oral tumor involving the alveolar process of the mandible and the neck contents attached to the mandible were removed en masse. The oral cavity was closed by approximating the mucosal edges. If the tongue has been excised, the edge of the tongue is used to approximate the buccal mucosa, thus closing the cavity. The suture line is reinforced to prevent leakage whenever possible. The lip is reconstructed with chromic catgut sutures for the muscles and interrupted finet silk sutures for the skin. The neck wound is always drained. A tracheotomy was included in this procedure. The neck wound is always drained, but an innovation about five years ago has proved very useful. This is the insertion, beneath the neck flaps, of a straight French catheter, with added openings along the side. The distal end is attached to a closed water-trap suction. This reduces the bulkiness of the dressing to the neck and facilitates the care of the wound as well as adding to the comfort of the patient.

Postoperatively, the mandible is stabilized by one of a number of methods. In this particular case, the right mandible was wired in occlusion to the teeth above.

Case 5

The patient was a 55 year old man who sought treatment for an ulcer of the left gingivobuccal sulcus of three months' duration. He had chewed tobacco for the past 35 years. Physical examination revealed leukoplakia covering the mucosa of the alveolar process, of the gingivobuccal sulcus, and the buccal mucosa. There was an ulcerating lesion within the gingivobuccal sulcus and invading the alveolar process. There was one rather firm node in the submaxillary space. A combined operation, radical neck dissection plus hemimandibulectomy, was carried out. A Kirschner wire was used to stabilize the mandible. One end was placed into the cut end of the mandible and slightly bent to conform to the configuration of the opposite side. The other end of the wire was placed in the tip of the mastoid process. Since the mucosa and muscular floor of the mouth were not involved, there was adequate mucous membrane with which to close the oral cavity. This was reinforced over the Kirschner wire and the wound closed. It was found that the stability of the mandible and the mobility of the tongue were such that a tracheotomy was not thought necessary. This proved to be the case and the wound healed by primary intention.

About 18 months postoperatively, between the patient's usual visits to the tumor clinic, he came one day with an erythematous tender area over the distal end of the mandible. The end of the Kirschner wire was felt, apparently just beneath the skin. Through a small incision, the end of the wire was grasped by Kelly clamp and removed. Following the removal of this prosthesis, the bone end was found to be stable, and the symmetry of the face is such that future reconstructive procedures on this particular patient are not contemplated.

Summary

Between 5 and 6 per cent of all malignant lesions occurring in man are found within the oral cavity. The etiology is not fully understood, but it would seem that tobacco, alcohol, poor oral hygiene, and syphilis certainly play a role in the disease.

Epidermoid carcinomas make up the majority of the cancers of this region. Leukoplakia, a precancerous lesion, gives rise to malignant degeneration in about 50 per cent of the cases. Management of these lesions depends on their location, size, histology, and general behavior. As practicing otolaryngologists, we are afforded the opportunity of seeing these patients perhaps earlier than any of our colleagues. With a high index of suspicion on our part, the five-year survival rate should be improved.

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A Clinical Report On The Use Of Combined Mandelamine And Thiosulfil In Resistant Urinary Tract Infections*

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This is the second report on our use of combined Mandelamine and Thiosulfil in chronic resistant infections of the urinary tract. It involves clinical evaluation only, whereas a previous paper recently published¹ reported a series of laboratory experiments.

The problem of increased occurrence of resistant strains of bacteria—particularly the coliform bacilli—in chronic urinary tract infections has in recent years become quite grave. It is evident that modern antimicrobial therapy is not measuring up in coping with the increasing morbidity resulting from bacterial invasion of the urinary tract.

Antibiotics as well as sulfonamide drugs in most acute infections, where no obstructive factors or anomalies are present, are quite effective if properly administered. In chronic or recurrent infections, however, particularly where stasis or foreign bodies are involved, they are not only ineffective but too commonly enhance the development of multiple pathogens of varying resistance to the point that specific therapeutic cure by their use is impossible.

This fact is very noticeable in a urologic practice, where most patients will have already undergone treatment with antibiotics and other chemotherapeutic agents without cure, and urine cultures reveal one or more resistant types of bacteria. In such instances, even after stasis and obstruction are relieved, the invading organisms have established such a foothold and such a strong

resistance to modern agents that cures with the most careful selection of drug are rare.

It is our belief that recurrence and chronicity of infections are the same and almost invariably indicate some abnormality in the urinary tract. Obstruction with stasis may occur at any level from the collecting tubules of the kidney to the urethral meatus and by stagnation or foreign body perpetuate bacterial multiplication and reinfection of other parts of the urinary tract. Many of these factors are obvious and can be relieved surgically, while others cannot. Furthermore, we believe that in combatting chronic or recurrent infections the approach should be logical and intensive. After thorough evaluation and surgical removal of any complicating factor, antimicrobial therapy should be instituted and continued until a cure is thought to be obtained. If the therapy is found to be effective and non-toxic, it should then be continued for many weeks in decreased dosage as a prophylactic against recurrence.

The Search for an Effective Combination

Our experience with antibiotic therapy in chronic urinary infections has been quite unsatisfactory even where sensitivity tests indicated a probable good response. That both antibiotics and sulfonamides exert their greatest effect in the blood serum and the tissues while having little effect in the urine and on the uroepithelium, where bacteria often breed luxuriantly, is one reason for poor results with their use in chronic urinary infections. Another reason is their narrow spectrum and their tendency to allow resistance to develop before a cure is effected.

This observation brought about a change in our thought concerning the problem

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about seven years ago. We remembered that more than 40 years ago methenamine, by virtue of formaldehyde liberated in an acid urine, was known to demonstrate bactericidal properties in the urine and on the uroepithelium, and was particularly effective in obstructive uropathy. We also remembered that 20 years later ketosis, by creating a urine of low pH, often wiped out severe chronic bacillary infections. This discovery was the forerunner of mandelic acid, which for years was our best weapon against the coliform organisms.

It is generally recognized that methenamine and acidifying drugs act almost entirely within the urinary stream and have no value proximal to the collecting tubules. Sulfonamides and antibiotics, as previously stated, exert most of their effect in the blood stream and urinary tissues. With this knowledge as a basis for clinical experimentation, we decided to combine drugs which act in the affected tissue and those which are bactericidal in the urine. Furthermore, we felt that we must consider drugs which were not vulnerable to resistance and could be used over long periods of time without toxic effects, hoping eventually to sterilize the urinary stream while acting within the tissues.

The cost of antibiotics for prolonged therapy, together with their lack of broad spectrum quality, and even more important their tendency to produce an overgrowth of resistant strains, militated against their use in this clinical trial.

A sulfonamide, if found to be safe in an acidified urine, appeared to be the most desirable chemotherapeutic agent to try in combination with methenamine and an acidifying drug. At this time we were using several highly soluble and relatively non-toxic sulfonamides which had appeared on the market. The one which impressed us in our experience as being least toxic and least likely to block the kidney tubules and ureters in a low pH medium was Thiosulfil.

Early Experiments

In 1953 Mandelamine and Thiosulfil, each in the dosage of 0.5 Gm. were tried together on several patients who had resistant in-

fections but adequate renal function. The decision to try this combination in our earliest cases was more or less a desperate move in that previous therapy with antibiotics and Furadantin had failed. To our amazement, good results were obtained in a large percentage of cases and no untoward effects were noted. Becoming bolder, we instituted this therapy in many cases of rather advanced renal insufficiency with favorable effect and no noticeable renal acidosis or toxicity from cumulation in the serum. Before attempting any basic research on this agent or analyzing the clinical results, well over 500 cases were so treated, none of which evidenced any untoward effect. An occasional patient showed evidence of the milder toxic effects of sulfonamides, such as headache and skin rash, but no oliguria or anuria was ever noted.

It was suspected that in urea-splitting infections the ammonium chloride in Mandelamine might react adversely in enhancing the elimination of more ammonia and failure in lowering the pH of the urine. Furthermore, it later became known that the effectiveness of ammonium chloride is short-lived because of the renal adaptive mechanisms of the tubules to conserve sodium with increased excretion of ammonia. For these reasons, ammonium chloride was later eliminated from the drug combination, although no untoward effect had been noted in its use previously.

Current Study

Laboratory trial

Late in 1959, the Ayerst Laboratories made up a combination of mandelic acid, methenamine and Thiosulfil in tablet form for a trial use by us. Before running a further clinical series, we conducted a laboratory experiment¹ using Mandelamine and Thiosulfil separately and then in a combination against resistant coliform organisms. The organisms were *Pseudomonas*, *Proteus* and *Aerogenes*, which on sensitivity studies showed complete resistance to penicillin, dihydrostreptomycin, tetracycline, chloramphenicol, and Furadantin. The results were extremely good and showed a definite ad-

Case	Diagnosis	Organism	Py- uria	Therapy Duration	pH	Turbid- ity	Toxi- city	Results	
								Good	Failure
1.	Pyelonephritis & Diabetes	Aerobacter	4 +	3 mos.	5	1 +	0	Yes	
2.	Pyelonephritis & Renal Stones	Coliform	4 +	2 mos.	6	2 +	0	Yes	
3.	Cystitis, Post TUR	Paracolon	4 +	1 mo.	5	4 +	0	Yes	
4.	Polycystic Disease	Coliform	3 +	1 mo.	6	2 +	0	Yes	
5.	Bilateral Hydronephrosis & Pyelonephritis	Aerobacter	1 +	1 yr.	5.5	2 +	0	Yes	
6.	Renal Stone & Pyelonephritis	Staph. Aureus	3 +	1 mo.	5.5	3 +	0		Yes
7.	Bilateral Staghorn Stone & Pyelonephritis	Proteus & Aero-bacter	3 +	2 mos.	5.5	2 +	0	Yes	
8.	Cystitis	Alkaligenes	4 +	6 wks.	5.5	1 +	0	Yes	
9.	Cystitis	Coliform	4 +	2 wks.	6	0	0	Yes	
10.	Cystourethritis	?	1 +	1 mo.	?	?	0	Yes	
11.	Bilat. Renal Calculi	Proteus, E.Coli	4 +	4 mos.	5	2 +	Sl. Nausea		Yes
12.	BPH & Cystitis	Strep. Fecalis	4 +	2 mos.	4.5	3 +	0		Yes
13.	Staghorn Stone	Proteus, Para-colon	4 +	4 mos.	6	3 +	0	Yes	
14.	Paralytic Bladder	?	4 +	4 mos.	5.5	Trace	0	Yes	
15.	Paralytic Bladder	Aerobacter	4 +	3 mos.	5.5	3 +	0	Yes	
16.	Pyelonephritis & Ectopic Ureter	Aerobacter & Coliform	2 +	1 mo.	5.5	1 +	0	Yes	
17.	Pyelonephritis, Uremia & BPH	Coliform	2 +	2 mos.	5.5	2 +	0		Yes
18.	Recur. Renal Calculi	Aerobacter	1 +	3 mos.	5.5	2 +	0	Yes	
19.	Recur. Renal Calculi	Proteus & Pseudo.	3 +	4 mos.	6.5	0	0	Yes	
20.	Recur. Renal Calculi	Proteus & Coli-form	3 +	6 mos.	6	0	0	Yes	
21.	Bilat. Staghorn Stones	Proteus, Aero-bacter	4 +	3 mos.	6	2 +	0	Yes	
22.	Recur. Prostatitis & Pyelonephritis	Coliform	2 +	6 mos.	5.5	2 +	0	Yes	
23.	Chr. Pyelonephritis	Coliform	3 +	2 mos.	5.5	2 +	0	Yes	
24.	Chr. Pyelonephritis	E. Coli.	3 +	6 mos.	6	1 +	0	Yes	
25.	Chr. Urethrocystitis	Paracolon	2 +	6 mos.	5.5	2 +	0	Yes	
Total Cases 25								21	4

Fig. 1. Twenty-five cases of persistent urinary infection treated with AY-5803 (Mesulfin).

vantage in the effectiveness of the combined drug, particularly against *Proteus*, over either one singly.

Clinical series

Using AY-5803,* which was furnished by Ayerst Laboratories, a small series of selected patients with resistant organisms was subjected to this treatment (see figure 1). All complications such as stones, diverticula, and obstructions had previously been surgically relieved as far as possible. No case was included that had not been previously treated without success with the various other agents. In most instances the dosage was two tablets four times a day, but in a few it was only one. The over-all results were gratifying, and in a few in-

stances appeared almost miraculous.

Of the 25 patients 21 showed apparent cure. They were symptomatically relieved and the urine became normal on the basis of the microscopic disappearance of pyuria and bacteruria. Follow-up cultures have not been done in the majority of cases. None of these patients showed only bacteruria, and all evidenced a heavy pyuria before treatment was begun.

Four patients failed to respond to the drug. In one a pure culture of *Staphylococcus aureus* was obtained after removal of a ureteral stone. This organism was immediately eradicated with Albamycin after failure with Furadantin and chloramphenicol. Another resistant organism encountered was *Streptococcus fecalis* in a case of intractable prostatitis complicating benign

*The trade name given AY-5803 is Mesulfin.

hypertrophy. A third failure occurred in a patient with bilateral renal calculi in whom the stones were not completely removed. The fourth and final failure was in a patient with bilateral advanced pyelonephritis complicated by prostatic hyperplasia. Even with a successful prostatectomy, renal distortion was too marked for a possible cure in his case.

Early in our experience we noted a frequently occurring turbidity of the urine which varied from a mild cloudiness to a "buttermilk" flocculency. This was disturbing to patients but was found to have no relationship to the therapeutic response of the infection. Apparently the lower the pH, the greater the turbidity. Qualitative analysis of this sediment showed ammonium, uric acid, oxalate, calcium, and phosphate ions. There were no sulfa crystals large enough to be morphologically evident under the microscope. Apparently the flocculency was due to amorphous deposits of the varying ions resulting from a lowered pH in the urine, and became more marked after the urine cooled.

Discussion

The purpose of this report is primarily to give an undetailed clinical evaluation of a new combination drug which in our hands has shown superior therapeutic efficacy against chronic resistant infections of the

urinary tract. It is evident from table 1 that therapeutic response is often slow and requires time and patience. It is also evident from our experience that therapeutic effectiveness if once proven is continuous and is not retarded by the development of resistance such as occurs with antibiotics. For this reason if the early response is favorable, therapy should be continued until the infection clears completely, a process which may require months or longer.

It is our hope that this preliminary report will stimulate a widespread use of Mesulfin as a trial by the profession in chronic bacillary urinary tract infections, and that more detailed reports of its safety and therapeutic value will be forthcoming soon.

Summary

This paper is a report on 25 current cases of resistant urinary tract infections treated by a combination of Thiosulfil, mandelic acid, and methenamine. It is our opinion that such a combination is superior to other antimicrobial agents in that it is relatively free from toxicity, continuous in its action, and has the advantage of waging a twofold attack on bacteria—that is, in both the tissues and the urinary stream.

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... What doctors ought to be is what I call progressive conservatives. There need be no conflict between the two.

They should *conserve* the essentials that enabled them to provide the best care in the world for the 75 per cent, or whatever the figure is, but should not stop there. They should move on—*progress*. They should not abandon principles proved sound, but should find means to apply them in changing ways to changing situations, so as to reduce steadily the part of the glass that is empty.—Judd, W. H.: Physicians in a Changing World. *New England J. Med.* 263: 896 (Nov. 3) 1960.

The Classification and Medical Management of Diseases of the Middle and Inner Ear

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Obviously, in the short time allotted it will be impossible to discuss the medical management of all the diseases that affect the middle and inner ear. The purpose of this paper is to present a simplified classification of these diseases and to discuss in some detail a few of the more important entities.

As we all know, most of the recent advances in otology have been surgical. Very few really new concepts regarding medical management have appeared since the advent of antibiotics. In fact, some of our present day therapeutics may be traced back to antiquity. Witness the following remedies for the ears taken from a Greek medical papyrus of the second or third century A. D.¹

Medication for an ear that is watery. Salt, heat with good wine; you apply after cleansing it first; apply to it for four days.

This is not far removed from the alcoholic acid solutions used today.

The Coptic Medical Papyrus of the ninth or tenth century A. D. has the following advice:

Ear which suffers acutely. Opium, calf's fat and milk: melt them together, warm them and apply to the ear. The pain will stop instantly. But do not administer this remedy to a man until you have received your fee.

Apparently this remedy worked so well that payment was demanded in advance.

The Middle Ear

Diseases of the middle ear are classified as follows:

1. Congenital malformations
2. Injuries
 - Tympanic membrane

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- Middle ear structures
 - Aerotitis media
- 3. Serous otitis media
 - Acute
 - Chronic
- 4. Catarrhal otitis media
 - Acute
 - Chronic
- 5. Suppurative otitis media
 - Acute
 - Chronic
 - Non-dangerous (Central)
 - Dangerous (Marginal)
- 6. Specific infections
 - Tuberculosis
 - Syphilis
- 7. Tumors
 - Benign
 - Malignant
- 8. Otosclerosis
- 9. Diseases of the facial nerve
 - Sensory
 - Ramsay Hunt syndrome
 - Geniculate neuralgia
 - Motor
 - Central
 - Peripheral
 - Injury
 - Bell's palsy

Conditions primarily of a surgical nature will not be discussed here. Congenital malformations fall into this category. The only injury to be discussed is aerotitis media, which I have classified as an injury because it has to do with the traumatic effects of alteration of barometric pressure. "Otic barotrauma" is probably a better term, as it implies not only injury from flight but also from underwater locomotion. Treatment consists of the institution of measures to open the eustachian tube block and subsequent equalization of pressure. The patency of the eustachian tubes must be maintained to allow healing of the traumatized structures and removal of the serous and serosanguineous fluids from the middle ear. The most practical method of treatment is some form of constant-pressure politzerization delivered at a pressure of about 2 pounds. This is done after shrinking the eustachian tube orifices with vasoconstrictive

tors. Catheterization should be reserved until other methods have failed, as it may increase tubal obstruction. Paracentesis using a small needle with aspiration has been employed successfully by Canfield and Bateman². Needless to say, nasopharyngeal conditions, whether infectious or allergic, must be treated with the object of correcting the immediate condition and preventing recurrences.

In attempting to classify inflammatory diseases of the middle ear, the most perplexing problem encountered is the confusing terminology used to describe the various pathologic processes. Admittedly, this classification is oversimplified. The disease processes are not sharply demarcated and, with or without treatment, may change from one stage to another. For example, serous otitis may rapidly develop into acute suppurative otitis if infection is introduced. Likewise, a case of acute suppurative otitis with effusion may, after treatment with antibiotics, resemble chronic serous otitis. Frequently, an adequate history is the only indication of the sequence of events.

Treatment of the catarrhal stage should be directed toward the nasopharyngeal disease and the re-establishment of tubal patency. Decongestants are useful in promoting tubal drainage, and systemic antibiotics should be administered to prevent active suppuration from developing.

An acute serous otitis may respond readily to treatment of the nasopharyngeal process, whether infectious or allergic. Nasal decongestants, antihistaminics, pneumomassage, politzeration, and catheterization are all useful, and produce rapid control of most acute situations. Many of our problems, however, arise in the patient with chronic serous otitis and thick, tenacious fluid. This is usually a child with a history of one or more bouts of acute suppurative otitis treated with antibiotics. Clinically the patient is well, and the only complaints are of stuffy ears and hearing loss. If the condition is allowed to persist, chronic adhesive otitis will develop, with permanent impairment of hearing.

Numerous methods of dealing with these problems have been advocated. Cortisone³

and parynzyme⁴ have been injected into the middle ear. In resistant cases, Armstrong⁵ suggests the use of a small polyethylene tube placed through the pars tensa. We have found that paracentesis with aspiration, using a double barrel needle, gives the best results. Occasionally the fluid is too thick to remove by this method and a myringotomy is necessary, along with active suction. In recurrent cases we have used Armstrong's method with good results. In the older patient with chronic serous otitis, the possibility of a nasopharyngeal tumor must be considered.

Chronic drainage

Acute suppurative otitis media will not be discussed in detail, but I would like to mention the management of the chronically draining ear prior to surgical intervention. Active medical treatment to reduce the inflammatory reaction contributes greatly to the success of operation. Many patients do not appreciate the seriousness of their disease and are reluctant to submit to surgery. It is our responsibility to follow and treat these patients medically, always being alert to possible complications.

The medical treatment of chronic suppurative otitis media is primarily local. The most important single procedure is adequate cleansing of the ear either by suction, irrigation, or a combination of the two. Powders such as boric acid, Sulzberger's or various antibiotic powders may be insufflated into the ear. We have been pleased with the effectiveness of topical antibiotics combined with small amounts of hydrocortisone, such as that found in Cortisporin. Correction of the nasopharyngeal disease with re-establishment of tubal patency is of the utmost importance. Especially is this true if surgery is contemplated. Radiographic studies using contrast media, as advocated by Compere, are useful⁶. We have found that injecting a solution into the middle ear and noting whether the patient tastes the solution is simpler and effective.

Specific chronic infectious diseases of the middle ear such as tuberculosis and syphilis are rare, and will not be discussed. Tumors and otosclerosis are, of course, primarily surgical lesions.

Involvement of the facial nerve

Ramsay Hunt, in 1910, described a syndrome consisting of herpes zoster involvement of the sensory portion of the facial nerve, the nervus intermedius⁷. The motor facial nerve may be involved by contiguous inflammation. Treatment is largely symptomatic. Diathermy or irradiation over the affected ganglion may be beneficial. Intravenous sodium iodide, vitamin B₁₂, or Protamide may help to relieve the symptoms. Broad spectrum antibiotics have been used, but are probably of little value. Geniculate neuralgia is probably a variation of the above condition.

It is generally felt that Bell's palsy results from interference with the blood supply of the facial nerve. Current forms of treatment are directed at the rapid relief of angiospasm, the prevention of secondary thrombosis, and the reduction of swelling. Vasodilator drugs, such as nicotinic acid, are useful. Histamine or procaine given intravenously has been advocated. Korkis⁸ combines stellate ganglion blocks with corticosteroid therapy in order to produce rapid vasodilation and reduction of tissue edema. To be effective, the treatment must be instituted within 24 hours after the onset of symptoms. Physiotherapy utilizing heat, passive massage and electrical stimulation is useful.

The problem of the optimum time for decompression is still unsettled. The most widely accepted practice at present is to treat medically for six to eight weeks and then, if there is no faradic response or other indication of improvement, to advise decompression⁹.

The Inner Ear

The following is a classification of diseases of the inner ear.

1. Congenital Deafness
2. Non-inflammatory diseases
 - Injuries
 - Drugs
 - Noise induced
 - Vascular
 - Anemia
 - Vasospasm

- Hemorrhage
- Presbycusis
- Meniere's syndrome
 - Meniere's disease
 - Pseudo-Meniere's disease

3. Inflammatory diseases
 - Specific infections
 - Labyrinthitis
 - Circumscribed
 - Serous
 - Localized
 - Diffuse
 - Suppurative
 - Manifest
 - Latent

4. Tumors
5. Motion sickness
6. Psychogenic deafness

In discussing diseases of the inner ear, the major emphasis will be placed on drug toxicity and Meniere's syndrome.

Toxicity

It is well known that a number of drugs exhibit a strikingly selective toxic effect upon the labyrinth and cochlea. These drugs include salicylates, quinine, and the family of basic Streptomyces antibiotics. Recently kanamycin was introduced. This drug belongs to the basic Streptomyces family, which also includes streptomycin, dihydrostreptomycin, neomycin, viomycin and, more recently, vancomycin. Reports in the literature demonstrate the ototoxicity of kanamycin¹⁰. Interestingly, virtually all patients developing ototoxicity had impaired renal function. Recently a 40 year old woman was referred to our clinic because of sudden onset of deafness. She received 19 Gm. of kanamycin initially. Three weeks later tinnitus developed and two months later she was given an additional 15 Gm. of kanamycin, with almost total loss of hearing resulting. Her blood urea nitrogen ranged between 50 and 123 mg. per 100 ml. during this period.

Vitamin B₁ has been reported to have arrested and even improved hearing loss produced by ototoxic drugs¹¹. To be effective, this must be given at the earliest indication of toxicity. Dosage suggested is 100 mg. daily given intravenously for 10 days. If improvement is noted, the drug is continued once or twice a week for six

months. This case was one of a small series, and further work must be done to verify the observations.

Prebycusis

Presbycusis results from irreversible changes within the aging inner ear. Though this condition cannot be controlled, the frequently associated symptoms of tinnitus and dizziness may be helped. Reassurance and mild sedation are useful. A pillow microphone connected to a bedside radio is often helpful in tinnitus if the patient is unable to sleep. Vasodilators, Dramamine or Bonamine may provide symptomatic relief from dizziness.

Meniere's disease

True Meniere's disease has no specific treatment. The large number of drugs employed is indicative of their uncertain curative value. Temporary relief of an acute episode may be effected with hyoscine, belladonna, other anticholinergic drugs, and sedatives. Diuretics, especially acetazolamide (Diamox), combined with a low salt diet, have been widely used¹². Nicotinic acid may be helpful in preventing attacks. Fowler¹³ believes that "blood sludge" is an important causative agent, and has used anticoagulants, procaine, and nicotinic acid. He employs procaine hydrochloride, 0.1 of 1 per cent in 50 cc. of 5 per cent glucose in water, given over a period of 10 minutes twice daily. He feels that this drug is superior to histamine.

In our clinic we have had best results with intravenous histamine during the acute phase. We use 2.75 mg. of histamine phosphate, equivalent to 1 mg. of the base in 250 cc. of 5 per cent glucose in water, given rapidly twice daily. This is continued for five to seven days, after which frequency of injections is gradually diminished to once every one or two weeks. In addition, we frequently prescribe a low salt diet, diuretics, and nicotinic acid. It has been found more effective to combine the several methods of treatment—vasodilators to relax the arteriolar spasm, low salt diet to decrease endolymphatic hypertension, sedatives to relieve tension and anxiety, and

endocrine therapy when indicated—than to give one after the other. Approximately 75 per cent of patients with Meniere's disease can be relieved medically¹⁴.

Three types of labyrinthitis may develop as complications of middle ear suppuration—circumscribed, serous, and suppurative. The advent of the sulfonamides and antibiotics has markedly reduced the necessity for surgical intervention, though an experienced otologist should closely follow these patients and operate if necessary. Sedatives and drugs that reduce labyrinth irritability, such as Dramamine and Bonamine, are useful in serous or toxic labyrinthitis.

Conclusion

This paper has merely touched on a few of the more important diseases of the middle ear and inner ear that respond to medical management. Our knowledge of physiologic and pathologic processes, especially of the inner ear, is limited. Only through the investigative efforts of many individuals will we be able to treat these diseases rationally in the future.

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Surgical Management of Diseases of the Middle and Inner Ear

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Through the ages deafness has been difficult to treat and harder to cure. Today, thanks to new clinical observations, better concepts of physiologic acoustics, new electro-acoustic techniques, along with highly complex surgical procedures, deafness, once a serious and growing problem, is no longer considered hopeless.

The human system of sound conduction has been known since the early Greek physicians; however, little progress was made in the physiology of hearing until the advances of Vesalius, Ingrassia, and Fallopius in the sixteenth century. The physiology of hearing was later explored by many men, but only during the last quarter-century has this information been applied systematically to the surgical reconstruction of the sound-conducting mechanism. It remained for such men as Sourdille¹, Holmgren², Lempert³, Rosen⁴, Zöllner⁵ and Wullstein⁶, among others, to apply these principles surgically. At present, conductive hearing loss is the only type amenable to surgical intervention.

Otosclerosis

Otosclerosis is a primary disease of the osseous labyrinthine capsule. It may be localized to a few areas but is usually more widely dispersed. Impairment of hearing results when the sound conduction mechanism is interfered with at either window.

Ankylosis of the stapes was first noticed by Valsalva in 1735; however, it remained for Politzer, in 1893, to describe the histologic findings. Up to this time it had been thought that stapes ankylosis was secondary to chronic middle-ear disease. Today otologists recognize otosclerosis as a condition that accounts for a great number of the cases of progressive conductive hearing loss in adults.

The etiology of otosclerosis is not known; however, a strong hereditary characteristic has been noted. The tendency for the condition to be associated with other diseases affecting the temporal bone has been noted—in von Recklinghausen's disease, osteogenesis imperfecta, and Paget's disease. Various constitutional factors affect the clinical course. The age of onset varies from puberty to late middle adult life, with the majority of cases occurring between the ages of 15 and 25.

The histologic lesion consists of a localized focus which is usually circumscribed and clearly demarcated from the surrounding normal bone. The perivascular spaces about the vessels are enlarged, with bone resorption and replacement by fibrous connective tissue. Occasionally, osteoclasts may be seen. Osteoclastic resorption occurs, leaving irregular spaces filled at first by fibrous tissue and later by new bone laid down by osteoblasts. The process of absorption and replacement goes on irregularly within the focus. This otosclerotic bone stains more deeply than the normal capsule around it,

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being bluer in some cases and redder in others. Otosclerotic bone always lacks the islands of ossified cartilage that characterize the endochondral layer of the normal labyrinthine capsule. The predominant site of the otosclerotic focus is just in front of the oval window, the second most frequent site being the borders of the round window. In extensive otosclerosis, the entire promontory, foot plate, crura, the osseous semicircular canals, and the stapedial tendon may be involved.

The loss of hearing, which is conductive in nature, is explained by the stapes fixation. The increase in stiffness affects primarily the transmission of low tones. The mechanism of cochlear loss occurring in otosclerosis is not fully understood. It may be due in part to invasion of the perilymphatic space by otosclerotic bone, or to a toxic effect on the sensory epithelium.

Impairment of hearing begins insidiously. One ear may be affected before the other, but both are eventually involved in most cases. Tinnitus occurs in varying degrees and varies in pitch. Paracusis willisiana (improved hearing in the presence of a noisy environment) occurs when both ears are involved. Occasionally, attacks of vertigo may occur. The diagnosis is made when other forms of conductive hearing loss are ruled out. On examination the ear drum appears normal, but Schwartz's sign, a reddish hue on the promontory, may be present. The eustachian tubes have normal patency. Audiometrically, early cases are usually marked by a loss of low tone by air and normal bone conduction. In later stages, there may be a loss of high tone by air and bone conduction. The speech reception threshold is impaired, but the ability to distinguish phonetically balanced words at above threshold remains relatively good.

Improvement in hearing may be obtained by a hearing aid or by one of two methods of surgical intervention: fenestration or stapes mobilization. The advisability of surgery depends upon the degree of hearing loss, the measure of residual hearing, and the general health of the patient. Patients with uncomplicated otosclerosis—that is, without cochlear involvement—are ideal

candidates for either fenestration or stapes mobilization. They are also good candidates for a hearing aid. Many patients today select surgery without fully understanding the expected results, only because of the nuisance of wearing a hearing aid. The results in fenestration can be accurately predicted, as determined by Davis and Walsh⁷. The results in stapes mobilization are less predictable. Stapes mobilization may be done in all cases of otosclerosis suitable for fenestration, and even in some cases that are not, because of the greater closure of the air bone gap.

Fenestration

The earliest operations for otosclerosis were attempts to mobilize the stapes by Kessel in 1876 and Miot in 1890. Other unsuccessful attempts were made before Holmgren, in 1916, began a long series of operations on otosclerotic patients. Using newer techniques and more magnification he tried many different procedures and became convinced that it was possible to obtain long-term improvement.

Sourdille, attracted by Holmgren's work, reported in 1932 a multi-stage procedure for fenestrating the horizontal semicircular canal and covering it with a meatal flap. In 1937 Sourdille¹ reported improved hearing in 80 per cent of 140 patients. Nevertheless, his multi-stage procedure, extending over many months, was never widely accepted. It remained for Lempert³, in 1938, to develop the one-stage fenestration operation by endaural approach and thereby overcome the prejudice against surgical intervention for otosclerosis. However, reclosure of the fistula by osteogenesis remained the chief problem. Although further studies of osteogenesis have decreased this difficulty, in approximately 10 per cent of the cases the fistula closes. Lempert's approaches in temporal bone surgery made possible the present techniques in modern ear surgery.

Briefly, the fenestration procedure is indicated in patients with stapes fixation, an intact tympanic membrane, and an adequate cochlear reserve as measured by the air-bone gap in the speech frequencies. This should average not less than 25 decibels. If

the loss by bone conduction is greater than 30 db. at 2,000 cycles per second, there is usually a greater loss above and usually some loss at 1,000 cycles per second. The object of operation is to establish a sound pathway to the labyrinth, by-passing the fixed stapes, and sound protecting the round window by an air-containing middle ear to establish a phase differential between the windows. Whether sound waves enter the new fistula or the round window first is as yet unsettled.

The technique consists of using Lempert's endaural incisions to expose the mastoid cortex. The skin and periosteum are reflected from the bony canal posteriorly and superiorly to the annulus, and the tympanic membrane is elevated from the annulus. The mastoid cells are exenterated and the posterior and superior canal walls are taken down to the level of the annulus. The three semicircular canals are exposed, as is the short process of the incus and the head of the malleus. The bony bridge is removed. The incus is separated from the malleus and removed, as is the head of the malleus.

A pedicle flap is created from the skin and periosteum and thinned. The fenestrated site is prepared by removing the periosteal bone and the fenestra is opened by the cupola method to avoid fragmentation. The ideal fenestra is 1 x 3 mm., placed as anteriorly as possible. All bleeding should be controlled before the fenestra is opened. The previously prepared flap is packed in place over the fenestra. The packing is removed after the seventh postoperative day.

Variations of the technique are used, but the maintenance of aseptic techniques and adequate postoperative care are essential. Complications include depression of hearing within a few hours postoperatively, persisting from several days to weeks; complete or partial closure of the fenestra, postoperative labyrinthitis, suppurative labyrinthitis, secondary infection of the fenestrated cavity, and emotional disturbances.

In ideal cases, fenestration results in improvement up to the 25 db. level in approximately 90 per cent of the cases. Two years postoperatively, approximately 75 per

cent of the ideal candidates have threshold hearing or better.

Stapes mobilization

As stated previously, the earliest attempt to improve hearing was directed at the stapes itself by Kessel in 1878. Shortly thereafter Miot reported on a series of 250 mobilizations with improvement in 45 per cent of the cases. His technique was very similar to that used today. In 1899, Faraci reported 30 per cent improvement in hearing in 30 cases of stapes mobilization. It is inconceivable that after these early encouraging reports so little was done with the procedure during the next half-century. In 1952, Rosen⁴, in order to determine the degree of stapes fixation before fenestration, devised a method for palpating the stapes by using Lempert's transmeatal approach for tympanosympathectomy. During one of these procedures the stapes was accidentally mobilized, with even greater hearing improvement than the contemplated fenestration would have achieved, and the improvement has lasted. Rosen's earliest technique was to apply gentle pressure to the neck of the stapes. In the next several years numerous modifications of the technique were reported. In fact, one can hardly pick up an otolaryngologic journal without finding an article on stapes mobilization.

Any case of conductive hearing loss resulting from otosclerosis and with bone conduction above 30 db. from 500-2000 cycles per second is suitable for stapes mobilization. Stapes fixation due to chronic middle ear disease or congenital anomalies may or may not be suitable for this procedure. Exploration of the middle ear is justified, however, and if stapes mobilization is not practical, fenestration can be performed. In cases of otosclerosis where fenestration is not possible because of advanced cochlear involvement, stapes mobilization may be justified, since adequate mobilization may eliminate the conductive hearing loss and improve hearing in the speech frequencies. This is possible because the continuity of the sound-conduction mechanism is maintained, whereas in fenestration it is by-passed. In cases of bilateral

otosclerosis, the deafer ear is operated on first.

The procedure is performed under local anesthesia using strict aseptic technique. The entire procedure is done with the aid of the operating microscope or other means of magnification loupes, through an ear speculum.

The four quadrants of the external auditory meatus are infiltrated with a 2 per cent solution of Xylocaine with epinephrine. Incisions are made in the superior and inferior canal walls and elevated laterally to a point approximately 6 mm. from the tympanic membrane, and the skin and periosteum are elevated to the annulus. The flap and tympanic membrane are elevated from the sulcus and laid forward, exposing the middle ear. The chorda tympani nerve is mobilized and laid out of the way. In some cases it may have to be cut. The diagnosis is confirmed by inspecting the middle ear and palpating the stapes. A portion of the bony annulus and posterior canal wall may have to be removed with a curette or drill in order to visualize the footplate and crura and to increase working room.

Transincudal mobilization may be attempted, but most operators now attack the foot plate with fine picks and chisels, attempting to cut through the otosclerotic focus.

Since the otosclerotic focus is located anteriorly in 75 per cent of the cases mobilization may entail only a small amount of manipulation. Crural otosclerosis is less frequent, and crurotomy may have to be performed. Refixation is more likely to occur unless a portion of the crus is removed. In diffuse footplate otosclerosis, a vein graft with prosthesis, as described by Shea⁵, may have to be performed.

If the round window is completely closed by otosclerosis, neither stapes mobilization nor fenestration is indicated, since the prognosis is not favorable. House's method⁹ of opening the round window and placing a mucous membrane graft over it has been unsuccessful so far. Since varied pathologic conditions occur in otosclerosis, the surgeon should be fully prepared to perform a number of procedures, such as crurotomy, crural

repositioning, or oval window fenestration with vein graft and prosthesis, depending upon the findings at operation.

After mobilization and testing of hearing gain, the tympanic membrane and canal flap are replaced and the flap is held in place with Gelfoam. Postoperatively, the patient may be placed on antibiotics and the pack removed at any time after seven days. An audiogram is made after removal of the pack. Repeat audiograms are made after one and three months, then yearly.

The same complications that can follow fenestration may occur in stapes surgery; however, the morbidity is lower.

If after four months there has been no gain in hearing or the initial gain has dropped to the preoperative level, the ear may be revised if the initial pathologic condition warrants it, and the surgeon is prepared to perform a crurotomy or stapedectomy with vein grafts.

The final results of stapes surgery are equivocal because of the lack of adequate criteria for surgery and standard techniques. Some operators report only 25 per cent improvement and others as high as 80 per cent. At present, the patient should be informed preoperatively that his chances for a successful mobilization are 50-50. Rosen⁴, in 1957, reported on fenestration of the foot plate after unsuccessful mobilization of bicrural fractures, with lasting improvement in hearing. Further study is needed before this procedure is adopted.

There is still much to be learned regarding surgery for deafness, and it is hoped that in the next decade fresh ideas will help clarify the entire situation.

Otitis Media—Serous and Purulent

The surgical treatment of otitis media today is not a great deal different from its treatment 30 or 40 years ago. The ultimate aim is the removal of fluid, whether mucoid or serous, from the middle ear space and its extensions. Myringotomy with spot suction and/or Valsalva's maneuver will free the middle ear space of this fluid. The fluid may recur, and if it does, repeated myringotomies and suction may be necessary.

Many otolaryngologists are reluctant to

open an ear as a therapeutic measure for this condition. Politzer, in commenting on the procedure, stated that he "considered the operation, after an abundant experience, to be one of the most practically important and successful therapeutic expedients in diseases of the ear."

Since the fluid collects in the middle ear whenever the eustachian tube is obstructed, every endeavor must be made to find the cause. The most common cause is acute and chronic upper respiratory tract infection. Other factors include hypertrophied and diseased adenoids, nasal allergy and vasomotor rhinitis, otitis media which has been made sterile as a result of early chemotherapeutic treatment, aerotitis, enlargement of the peritubal lymph nodes, malignant growths in the nasopharynx, dental malocclusions, endocrine dysfunction, cardiac insufficiency, cardiovascular renal disease, the leukemias, severe anemias, structural abnormalities of the ears, nose, and throat, pregnancy, and biochemical and autonomic nervous system dysfunction.

The symptoms of serous otitis media are sudden onset of impaired hearing and a "stopped-up" feeling in the ear. Eagle has stated that the patient may hear or feel the fluid move in the ear on moving his head.

The diagnosis is made by the history, fork tests, and appearance of the drum. The drum is usually retracted, but in rare cases may bulge. Hoople¹⁰ has described an amber appearance of the drum as characteristic of serous otitis media, but states that this finding may be absent. A chalky white malleus handle may be seen in long-standing cases. There is a conductive hearing loss, and the Weber test will lateralize to the affected ear. If from the history, the appearance of the drum, and the hearing loss a definite diagnosis cannot be made, a diagnostic myringotomy should be done.

In cases which do not respond to repeated myringotomies after the suspected cause of the eustachian tube obstruction has been removed, some have used an autogenous vaccine made from cultures of the nasopharynx; others have used ACTH. Armstrong places a 1.5 mm. polyethylene tube in a

myringotomy opening and leaves it in place for one to five weeks. Brown has advocated self-politzerization as an effective home treatment. As a last resort, a simple mastoidectomy has been done.

Acute Otitis Media and Mastoiditis

The keynote in the management of acute suppurative otitis media is early and adequate drainage. As soon as bulging of the ear drum is noted, a large myringotomy should be performed. A specimen of the pus liberated from the middle ear should be obtained for culture and sensitivity studies so that the correct antibiotic therapy may be instituted. When the suppuration results from a complication of sinusitis, the primary infection must obviously be treated first. Repeated myringotomies may be necessary if the previously performed myringotomy closes prior to complete drainage and resolution. After myringotomy, the pus should be wiped or suctioned from the ear daily.

Rarely is acute otitis media without some degree of mastoid involvement. A blockage in the aditus may give a normal-appearing tympanic membrane with an acute mastoiditis. The etiology here would have to be assumed. In the vast majority of cases, the acute mastoiditis is secondary to acute otitis media with the eustachian tube as the avenue of infection.

In the management of acute mastoiditis, again the keynote is adequate drainage through a large myringotomy opening, together with appropriate biotic therapy.

The following are indications for a simple mastoidectomy in acute mastoiditis:

1. Persistence of pain, temperature, and discharge for three to four weeks in spite of adequate drainage and proper antibiotic therapy.
2. Continuance of otorrhea for four to six weeks in the absence of pain and fever. This sign usually indicates an "antibiotic mastoid" wherein the disease continues to progress.
3. Sagging or bulging of the posterosuperior canal wall.
4. Subperiosteal abscess.
5. Signs of meningeal irritation.
6. A positive blood culture.

In any case, the final decision to intervene surgically in acute mastoiditis can be made only after a thorough and careful analysis of the patient's signs and symptoms, clinical course, and the laboratory and x-ray findings. If the patient is improving with conservative management, operation may be delayed.

Chronic Mastoiditis and Suppurative Otitis Media

The surgical management of chronic suppurative otitis media and mastoiditis is the same.

On examination of the drum, the perforation may be central or marginal, single or multiple, and may vary from the size of a pinhole to total loss of the drum. The discharge is mucoid, purulent, or mucopurulent. (In tuberculous mastoiditis, it is watery and odorless unless there is secondary infection.)

Roentgenograms usually reveal sclerosing of the mastoid process.

In the management of chronic otitis media and mastoiditis, every attempt should be made to "dry" the ear before operating on it. An exception would be in the presence of such complications as facial palsy, suppurative labyrinthitis, lateral sinus thrombosis, and epidural or subdural abscess, when immediate surgery is indicated.

Every effort should be made to clear any and all aggravating conditions before operating on the ear. Such conditions would include diseased or hypertrophied adenoids, nasal obstruction, or sinus disease. If granulation tissue or polyps are present in the external auditory canal, an effort should be made to eradicate them. A biopsy should be made of the mass to rule out the possibility of a neoplastic process. A polyp (a non-tender, round, firm, pedunculated mass of granulation tissue covered with epithelial cells) which does not blanch on application of astringents or hemostatics may be removed by a small ear snare, but traction or pulsion should never be applied since the polyp may be attached to an important intratympanic structure.

After use of the snare, the base of the polyp should be cauterized with silver

nitrate, chromic acid, or trichloroacetic acid. Granulation tissue, which is an overgrowth of fibroconnective tissue, should be cauterized with the above-mentioned caustics.

When a cholesteatoma is present, removal with a curette or by irrigation may be tried if the tumor is confined to the middle ear. If it is in the antrum, a mastoidectomy must be performed to remove it along with the matrix. Whenever a cholesteatoma is treated conservatively, the possible complications must always be kept in mind—namely, erosion into the lateral semicircular canal, facial canal, lateral sinus, or cranial cavity.

Although the likelihood of obtaining a cure is good when a mastoidectomy is performed for removal of a cholesteatoma, it is possible for the tumor to force its way into the haversian canals of the bones, thus forming focal centers from which it may extend again.

In most instances it is not possible to tell beforehand exactly how radical a procedure will have to be done when a mastoidectomy is contemplated for removal of a cholesteatoma. The determination is made when the operation is being carried out. A tympanoplasty may have to be performed at the time of surgery to preserve hearing and close the drum perforation, if the disease is eradicated.

Tympanoplasty

Tympanoplasty, a term first used by Wullstein in 1953 to designate surgical reconstruction of the sound-conduction mechanism, is the culmination of nearly a century of middle-ear surgical techniques for the improvement of hearing. The dominance of middle-ear surgery for the eradication of infection during ensuing years is evident from the voluminous material devoted to the subject and from the opposition of such men as Ballance, Kerrison, Siebenmann, and Politzer. Lempert's one-stage fenestration operation in 1938 and his subsequent techniques, coupled with the advent of chemotherapeutic agents, lessened the urgency for surgery for the eradication of infection.

As Lempert's disciples increased the number of successful fenestrations, thought

turned to other types of middle-ear surgery for deafness. The revival of stapes mobilization by Rosen in 1953 was another milestone. Better understanding of the physiologic principles involved in sound-pressure transformation as first postulated by Helmholtz and expounded by others¹¹ quickened the advance of reconstructive surgery of the middle ear. In 1950 Moritz constructed a closed middle ear space in preparation for a later fenestration. Shortly thereafter Zöllner⁵ and Wullstein⁶ began writing about reconstructing the sound pressure transformer mechanism for the oval window and sound protecting the round window. At present every otolaryngologic journal contains at least one article on tympanoplasty.

Helmholtz, in 1863, explained the sound pressure transformer mechanism of the middle ear as the mechanical amplifier of sound waves by the tympanic membrane, the lever effect of the ossicular chain, and the increase in force due to the large size of the tympanic membrane acting upon the small stapes foot plate. These observations, though amazingly correct, were not applied to surgical reconstruction of the middle ear for nearly a century.

In the light of recent studies the lever effect of the ossicular chain is 1.3 to 1, and the effective ratio of tympanic membrane to stapes foot plate is 17 to 1. These values combined yield the sound pressure transformer ratio of 22 to 1. This equals 26.8 db., which is theoretically the best possible hearing that can be achieved by fenestration which by-passes the sound pressure transformer mechanism of the middle ear.

The intact tympanic membrane protects the round window. A perforation of the membrane removes the sound protection, allowing the sound to reach both windows at the same time. As long as the perforation is small and central the over-all effect is slight. As the perforation becomes larger, the transformer ratio diminishes, and with no tympanic membrane, there is a 40-50 db. loss. The effect of the phase shift in the sound protection mechanism remains to be studied more completely.

The object of tympanoplasty is to construct a closed air-containing middle ear

space for the round window and to restore sound pressure transformation for the oval window by various techniques dependent on the condition found at surgery.

Tympanoplasty should be considered in all cases of chronic suppurative otitis media with sufficient cochlear reserve and adequate function of the eustachian tube after the disease has been eradicated entirely. It should be delayed in cases of chronic suppurative otitis media with complication.

The type of operation in any case depends on the findings. Wullstein has grouped the structural defects and appropriate corrective procedures into these five types:

Type I. There is perforation of the tympanic membrane, central in type with normal mucous membrane in the tympanum. The ossicular chain is intact. Wullstein inspects the attic and antrum through holes made into these areas, and, if normal, proceeds to close the perforation by the use of a split-thickness skin graft after de-epithelialization of the drum and canal wall.

Type II. There are minor ossicular chain defects, but the chain is mobile, or can be made so. The tympanic membrane perforation usually affects the pars flaccida. The skin graft is laid over the perforation and ossicles so that the continuity is restored.

Type III. The continuity of the ossicular chain is destroyed, but the stapes is intact and mobile. The tympanic membrane or graft is applied on the head of the stapes to produce a columellar effect with an intact tympanic membrane.

Type IV. The continuity of the ossicular chain is disrupted and the crura of the stapes are destroyed, but the foot plate is mobile. A small closed middle ear is constructed to include the hypotympanum, round window niche, and eustachian orifice. The stapes foot plate is left exposed.

Type V. The stapes is fixed, or the crura are absent and the foot plate is fixed. A fenestration of the horizontal semicircular canal is performed, and a closed middle ear cavity is constructed as in Type IV and covered with a free skin graft. The fenestration may be done later.

For Types I and II, Lempert's endaural incisions may be used for exposure. The

attic and antrum are inspected by means of drill holes. The ossicular chain is mobile or made mobile. The skin graft is taken and laid in place after de-epithelialization of its bed, so that there will be no buried epithelium.

For Types III, IV, V, some prefer the Lempert incisions and others the postaural approach of Heerman or Wullstein for better visualization of the anterior portion of the tympanic membrane and sulcus. A semi-radical mastoidectomy is performed, with exenteration of all the cells and diseased tissue. Then a Type II, III, IV, or V procedure is performed, with the free skin graft depending on the pathologic findings.

Since there are as many techniques as there are, the techniques were only sketchily described. However, certain criteria are observed by all operators. An adequate preoperative examination and diagnosis is made. The eustachian tube function must always be good. At operation all diseased tissues should be removed or corrected. No epithelium should be left in the bed of the graft. As much of the middle ear mucosa should be preserved as possible; once removed, it cannot be replaced.

The most difficult part of the technique is placement of the graft to the margins of the de-epithelialized areas. Whether one uses a full or split-thickness graft is still open to question.

Postoperative care is the same as for a mastoidectomy. Controlled inflation of the middle ear, however may begin as early as the third day.

Tympanoplasty correctly done with subsequent hearing improvement is among the most difficult temporal bone procedures. Success or failure, even in the hands of the skilled surgeon, depends on many variables.

Of the causes for failure, the inadequate eradication of diseased tissue with subsequent necrosis of the skin graft is the most frequent. Other causes are: necrosis of the tympanic portion of the graft due to an inadequate blood supply; adherence of the graft to the medial tympanic wall due to excessive scarring; poor eustachian tube function; inadequate preparation of the graft bed, buried epithelium causing later

cholesteatoma formation; and the presence of small occult perforations which may cause later difficulty.

In the hands of experienced operators, the results have been good. Zöllner and Wullstein report only 28 per cent of 329 cases with no significant increase of hearing. Schuknecht¹² reported 94 per cent improvement in Type I, 56 per cent improvement in Types II and III, and 72 per cent in Type IV. Proctor¹³ reported 70 per cent improvement in Type II, 58 per cent in Type III, and 69 per cent in Type IV.

Surgical Considerations of Meniere's Disease

The diagnostic criterion of Meniere's disease has changed little from his description in the early 1860's: deafness, tinnitus, and vertigo.

Meniere's disease is characterized by episodic, recurrent, violent vertigo with hearing loss, tinnitus, nausea, and vomiting. Hearing loss is perceptive, with low or high tone losses. Distortion, diplacusis, and recruitment may be even more annoying than the vertiginous attacks. Caloric examination usually shows hypofunction on the affected side.

When the vertiginous attacks are incapacitating, endorgan ablation should be considered. Medical management will have been tried—and of course there are varied opinions as to what constitutes adequate medical management. Some of the methods used are psychiatric therapy, stellate ganglion block, both allergic and histaminic desensitization, antinauseant drugs, nicotinic acid, and other vasodilators. Dietary regimes include sodium restriction.

The difficulty of evaluating these and other modes of medical management is that many "Meniere-like" manifestations or "pseudo-Meniere's disease" have been included with the true disease in medical studies. Also, the remissions and exacerbations of Meniere's disease make any but long-term studies valueless. It is our feeling that, for the most part, ablation therapy is the only lasting treatment for the true case. Also, despite the frequent complaints of dizziness, Meniere's disease is a relatively rare entity. In addition, the auditory function in the

opposite ear should be reasonably good without evidence of progressive disease.

The first presentation in English of surgical procedures for intractable Meniere's disease appeared in 1904. Parry¹⁴ described intracranial division of the eighth cranial nerve, and Milligan¹⁵ described destructive labyrinthotomy. In the years that followed, modes of attack of this problem varied in favor of intracranial division of the eighth nerve versus labyrinthine surgery. Peacock, Mollison, and Wright injected 95 per cent alcohol into the labyrinth; however, this method entailed considerable risk of facial paralysis. In 1927 Portmann¹⁶ designated Meniere's disease as "aural glaucoma." Treatment consisted of aspirating a few drops of fluid from the endolymphatic sac. However, many regard this technique as difficult and facial nerve injury as well as recurrence of symptoms easily possible. In the early 1930's, dorsal sympathectomy was advocated but later discarded.

Intracranial section of the eighth nerve, introduced in 1904, was popularized by the writings of Dandy¹⁷, starting in 1928. Walsh, however, (1956) pointed out that the residual hearing after this procedure is usually useless. Operative damage to the cerebellum and adjacent cranial nerves can easily occur.

Another attempt at membranous labyrinth destruction with preservation of hearings was made by Day¹⁸ in 1943. He described a technique of labyrinthotomy, followed by destruction of the membranous labyrinth by electrocautery. Day himself, however, reported that hearing retained after operation is not useful. The incidence of facial paralysis with this technique was significant. Also, re-operation was occasionally necessary.

In 1954, Arslan¹⁹ applied ultrasonics to the labyrinth for Meniere's disease. He stated that with this procedure, the direction of the ultrasonic beam must be carefully determined to avoid damage to the facial nerve. The degree of nystagmus must be closely observed during therapy and treatment terminated when paralysis or nystagmus to the opposite side occurs. Proponents of this method state that the advantage is

selective destruction of the peripheral system of equilibrium without loss of hearing. Several treatments may be required. Again the question arises whether the residual hearing, which is often distorted, is worth saving, and facial nerve injuries can occur if the waves are not precisely directed.

Cawthorne²⁰, in 1943, described his technique of labyrinthotomy as effective in all but 4 of 52 cases. His present technique involves performing an attico-antrotomy with enough bone removed to insure a good view of the external semicircular canal. With a small dental finishing burr, preferably with magnification, a fistula is made through the bony horizontal semicircular canal. The membranous canal is then seized with fine forceps. Other methods of extracting the membranous canal include mechanical disruption of the labyrinth with barbed instruments (Lindsay and Siedentop²¹). Some use small right-angled "microscopic" hook to extract the membranous labyrinth. The mastoid wound is closed without a drain and a mastoid-type dressing is applied.

Schuknecht¹² describes a transtympanic labyrinthotomy. A stapes type canal flap is raised and the tympanic membrane elevated. The stapedius tendon is cut and the stapes removed. A small instrument with a curved tip is introduced through the round and oval windows and manipulated so as to disrupt the membranous labyrinth. A small suction tip is then used to aspirate the contents of the vestibule. The oval window is then occluded with Gelfoam to stimulate connective tissue proliferation, and the drum and canal wall are replaced and held in place by packing. The average hospital stay following this procedure is seven days.

Labyrinthitis is an occasional, but serious, sequel to otitis media. With the labyrinth exposed to infection, there is the possibility of suppurative or purulent labyrinthitis with total destruction of the labyrinth contents, or meningeal or intracranial involvement.

The different modes of labyrinthine infection include spread via the niches of the round and oval windows. This may be due to chronic infection, operative intervention,

or both. Infection is less frequent with direct erosion of the semicircular canals. Rarer still are cases of labyrinthitis resulting from myringotomy with dislocation of the stapes, skull fractures, and hematogenous spread.

From otitis media, there may occur serous labyrinthitis without permanent loss of endorgan function, or purulent labyrinthitis with total destruction of labyrinthine function. There may be a fistula of the labyrinth with or without labyrinthitis. In addition to the intracranial and meningeal complications of labyrinthitis, a dead labyrinth may result after the infection has ceased, and, on rare occasions, the bony labyrinth may sequestrate.

Except for occasional tumor, tuberculosis, or gumma, the history and physical findings may include a positive fistula test, vertigo, and labyrinthine nystagmus. Roentgenograms can suggest cholesteatoma. In most cases, findings will suggest cholesteatoma. Also, as mentioned, more serious intracranial signs may have occurred. Suspicion of a labyrinthine fistula is a definite indication for mastoid surgery.

Serous labyrinthitis quite often precedes the purulent form. The former may be difficult to distinguish from viral labyrinthine involvement; however, if it does not advance to the purulent form, labyrinthine contents are not usually severely damaged. Frequently related to otitis media and cholesteatoma, symptoms of vestibular serous labyrinthitis may include spontaneous nystagmus to the opposite side, variable perceptive loss, and a depression of labyrinthine function. Also, there are subjective vertiginous sensations as with Meniere's disease. Purulent labyrinthitis leads to complete loss of labyrinth function (D. H. absent caloric reaction, loss of caloric response). The latter symptoms are ominous, and the patient should be closely observed for intracranial extension. If this extension occurs, surgical drainage of the labyrinth should accompany the mastoidectomy.

Surgery of the labyrinth for purulent labyrinthitis is described by Richards²² in

1907. He described his technique of "uncapping" the semicircular canals with the gouge to inspect their interiors along with the vestibule. Present techniques involve a radical mastoidectomy, following which an opening is made in the horizontal semicircular canals as in a Lempert fenestration procedure. The endolymphatic labyrinth is then extracted. The stapes is removed and the oval and round windows are connected using a small drill. Fistula of the horizontal semicircular canal presents somewhat of another problem, particularly if there is evidence that the labyrinth is still functioning. A mastoidectomy can be performed with the inspection of the ossicular chain. The fistula area may or may not be seen and a skin flap laid over the horizontal canal.

In the past few years Rambo²³ has evolved a technique which utilizes a portion of the temporalis muscle in mastoidectomy. This is rotated as a pedicle flap over the area of the endaural opening. With its abundant blood supply, this flap allows safer covering of any chronically infected ear, including those with labyrinthine fistulas. Also, postoperative healing and cessation of otorrhea is reported to be much more rapid.

The primary consideration in operations for chronic otitis media with fistula is the patient's health and avoidance of serious sequelae. However, it has been noted (Permin²⁴) that hearing always deteriorates perceptively in chronic disease of the middle ear when a labyrinthine lesion supervenes. In the author's series of 50 cases of labyrinthine fistula, only half of the patients had any residual hearing at follow-up. After operation for fistular labyrinthitis, the fistular reaction persisted in only one-third of the patients.

Summary

The surgical management of middle and inner ear disease is discussed, with emphasis on deafness and descriptions of the stapes mobilization, fenestration, and tympanoplasty procedures. Also discussed was the surgical management of acute and chronic otitis media, serous otitis media, acute and



For as a plant turns leaf and bloom away
from the dark and toward the sunlight,
so will a wise man grow in the direction
of enlightenment.

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PATIENTS WITH HYPERTENSION

There was no blood pressure increase in any patient treated for bronchial asthma, and in some, blood pressure fell. Of these, three had been hypertensive.⁴

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Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. In the treatment of allergic respiratory disorders, dosage should be individualized and kept at the lowest level needed to control symptoms. Dosage should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

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5,000	7,500 to 15,000	75.00 Weekly	114.00	57.50	152.00	76.00
5,000	10,000 to 20,000	100.00 Weekly	150.00	75.50	200.00	100.00
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chronic mastoiditis, Meniere's disease, and labyrinthitis.

The need for meticulous eradication of the disease process cannot be over emphasized.

In no sense have we tried to state that any of these procedures are either simple, easy, or done without previous experience or supervision in temporal bone surgery.

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All of us would hope that, in the years ahead, the teaching centers would continue to play an important role in the development of the nation's medical research program. However, great attention must be given to seeing to it that with the enlargement of the research program the fundamental mission of our teaching centers is not lost. Certainly the undergraduate program of medical education represents the keystone of our future health in this country as far as medical manpower is concerned.—Hinsey, J. C.: Ingredients in Medicine Research—The Story of a Method, *The Pharos* 24: 22 (Jan.) 1961.

Pyloric Stenosis in an Infant, Due to Aberrant Pancreas and Hypertrophic Pyloric Musculature

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and

JOHN K. WILSON, M.D.

GREENSBORO

Aberrant pancreas, pancreatic rest, heterotopic pancreas, and ectopic pancreas are synonyms applied to pancreatic tissue that is not in anatomic continuity with the pancreas itself. Such rests are usually found in connection with the gastrointestinal tract, most commonly the stomach, but may be separated from it completely. Pyloric obstruction due to pancreatic rest has been reported in both children and adults, but we have found no report of pancreatic tissue being incorporated in hypertrophic pyloric muscle, with the typical hypertrophic pyloric stenosis syndrome. Pollock and others¹, in a review of 1,422 cases of hypertrophic pyloric stenosis, saw only one case wherein pancreatic tissue extended from the duodenum into the pyloric musculature, but the child did not have hypertrophy of the pyloric muscle.

Case Report

A 7 weeks old male infant entered the hospital with the complaint, as given by the mother, of vomiting. He had been a full-term infant, the first born of each parent (the mother was 21, the father 24). He was started on a formula of evaporated milk, but when 2 weeks of age was changed to SMA because of spitting. On this formula he improved, but still spat up a mouthful of formula occasionally. Cereal and baby food were started at the age of 5 weeks, with a noticeable decrease in the amount of spitting. Six days before admission he began spitting again. At first he spat only a few cubic centimeters of milk each time, but by the third day prior to admission he was vomiting all his formula. Dramamine was prescribed, and gave temporary relief. The day

before admission Banthine was given, with no effect. That day the vomiting became projectile. At this time the pediatrician was able to palpate a small tumor mass in the right upper quadrant of the abdomen; it had been felt for before, but not found. The baby was immediately referred to the hospital.

Complete examination showed a well developed, well nourished 7 week old male infant in good condition, with no apparent dehydration. The only abnormality found was a 2 cm. mass in the right upper quadrant of the abdomen. This mass was so easily discernible that even the parents could feel it. On the day following admission laparotomy was performed under general anesthesia. The pylorus was easily delivered into the wound. There was the expected firm cartilaginous ring around the pylorus, and in addition, on the lesser curvature margin was a mass measuring 2 cm. in diameter. It was decided to dissect off the mass and then open the hypertrophied muscle in the bed of the removed mass. The mass was easily separated from the remainder of the pylorus in much the same manner as the usual hypertrophic pyloric muscle splits. The remaining hypertrophic muscle was split down to the mucosa from the stomach to the duodenum, so that the area gaped open. There was no apparent perforation of the bowel. Bleeding was controlled by clamping and subsequent ligation with 0000 silk. The wound was closed in the usual fashion. Glucose in water was started by mouth, and retained, late in the afternoon of the operative day. A weak formula was started the next day and was rapidly increased to its former strength. The infant was discharged on the fourth postoperative day.

From the Departments of Surgery and Pediatrics, Moses H. Cone Memorial Hospital, Greensboro, North Carolina.

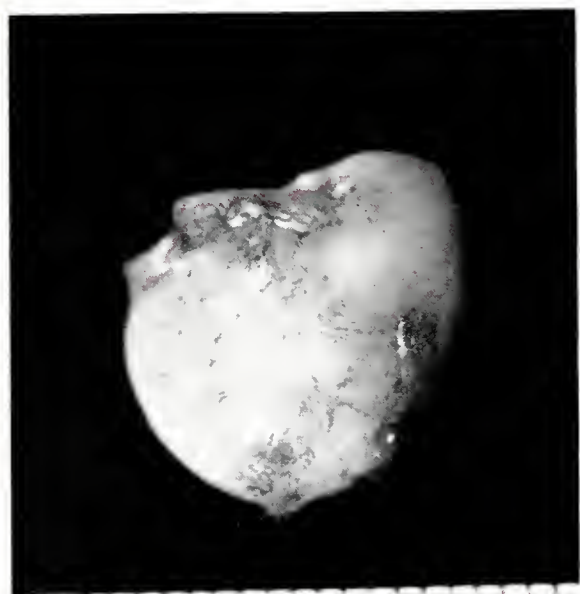


Fig. 1. Photograph of gross specimen. See text for description.

Pathologic report (Dr. James Harrop):

Gross: A firm gray oval nodule measuring 1.5 x 1 x 1 cm. was received for examination (fig. 1). On section it was found to be a tough fibrous capsule around a smooth-walled cavity, which measured approximately 5 x 5 x 5 mm., and contained clear mucoid fluid.

Microscopic: The capsule consisted of bundles of interlacing smooth-muscle fibers, intermeshed with many small collections of cells (fig. 2). These cells were mainly cuboidal, with an oval nucleus and slightly basophilic cytoplasm. The cytoplasm of the other cells was definitely eosinophilic. The cuboidal cells were arranged in acini resembling the acini of the pancreas. The more basophilic cells were arranged in round structures resembling pancreatic or bile ducts.

Diagnosis: Ectopic pancreas, clinically of pylorus.

Comment

Waugh and Harding² have reported 5 cases of pyloric obstruction due to hetero-

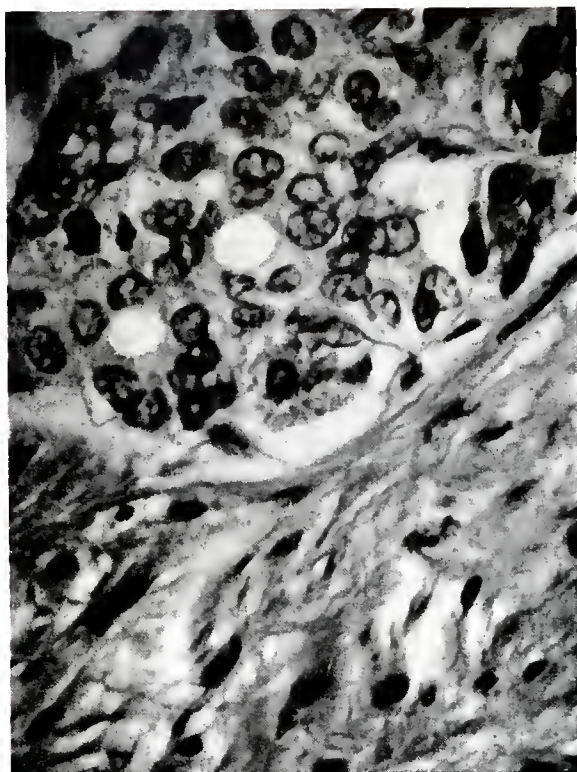


Fig. 2. High power photomicrograph. The fibrous capsule consisting of interlacing smooth muscle fibers is to the lower right, the pancreatic glandular tissue to the upper left.

topic pancreatic tissue, and in their report included an exhaustive review of the literature. Complications of heterotopic pancreatic tissue have included the diseases of the normally placed gland, together with obstruction, hemorrhage, intussusception, and malignant degeneration. Functioning adenomas may occur, causing hyperinsulinism.

In the case being reported the ectopic pancreas was thought to be an interesting but incidental finding. The pyloric obstruction was undoubtedly due to the hypertrophic muscle, although the ectopic pancreas was so placed that it could easily have caused obstruction. Both factors were corrected at operation.

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Chlordiazepoxide in the Treatment of Anxiety Reactions

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WINSTON-SALEM

A series of 36 office patients, 29 with diagnoses of anxiety, were given chlordiazepoxide (Librium*) in divided doses of 75 or 100 mg. every 24 hours. Good to excellent results were obtained in 25, fair to poor in 3, and no response in 8 cases.

The drug was found to be an extremely advantageous agent for the treatment of anxiety reactions and for the alleviation of anorexia and insomnia. Except for decreased libido in 8 females, perhaps related to the high dosage, side effects were minimal or absent.

The preliminary trials of Librium involved thousands of patients in private practice, clinics and hospitals, including more than half the medical schools of the country. The fact that this compound demonstrated properties of an entirely new type justified the unusual pains taken in its clinical appraisal¹. While the published reports indicate that the drug may play an unexpectedly versatile role in various branches of medicine, its function in psychiatry is paramount.

The specific action of Librium in relieving the symptoms of anxiety and tension has been well documented². These symptoms, especially the anxiety reaction, are basic to such neurotic manifestations as overt nervousness and jitteriness, withdrawal, self-distrust, phobic reactions, and depression. The somatic components of the anxiety state also fall into a familiar pattern that includes headache, gastrointestinal upsets, chest pains, numbness, and other vague complaints. We have observed that two symptoms are preponderant in the psychoneurotic patient: anorexia and insomnia. They usually occur together and, if uncontrolled, are important factors in the deterioration of the emotionally disturbed patient, contributing to a vicious circle of increasing anxiety and physical depletion.

In conducting a study of the over-all effect of Librium on a small series of psychoneurotic office patients, it was therefore proposed to note the influence of this drug on appetite and sleep patterns.

Material and Method

The 36 patients chosen for study included 20 women and 16 men, all in the active years of life ranging from 20 to 59. The age distribution was as follows:

Years	No.
20-30	7
30-40	16
40-50	8
50-60	5

Chronic or acute anxiety reaction was the predominant diagnosis, occurring in 29 of the group. There were 3 cases of depression and one each of manic-depression, obsessive-compulsion, schizophrenia, and phobic reaction. These disturbances had persisted from 4 months to 12 years; in the majority of cases the patients had been ill for one to two years. Some of the more seriously affected had been hospitalized for electroshock therapy, and most of the group had received various psychotropic drugs which had failed to relieve their symptoms.

Complete blood counts and urinalyses were done at the initiation of therapy and at regular intervals during the study.

The usual daily dosage of Librium was 100 mg. in divided doses of 25 mg., the last taken at bedtime. Some patients received the 25 mg. only three times a day. When indicated, the patients who had been taking the drug for some weeks were gradually shifted to a maintenance dose of 25 mg. twice daily.

The maximum duration of therapy is four months at the time of the present report. However, most of the patients are being continued on Librium.

Results

Of the 36 patients in the series, 25, or approximately 70 per cent, showed good to

From the Department of Psychiatry, Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, North Carolina.

*Trademark of Hoffmann-LaRoche, Inc., Nutley, New Jersey.

Table 1

Results in 36 Patients on Diagnosis	No. Cases	Librium Good to Excellent	Therapy Fair to Poor	No resp.
Anxiety reaction	29	22	1	6
Depressive reaction	3	1	2	
Manic-depressive	1	1		
Obsessive-compulsive	1			
Schizophrenic reaction	1			
Phobic reaction	1	1		
Total	36	25*	3	8

*Good to excellent results in 69.4 per cent.

excellent results of treatment (table 1). In 3 patients the effects of the drug were only slight, and in 8 there was no response. The marked improvement in those individuals who were benefited by Librium is suggested in the typical case studies presented below:

Case 5

The patient was a 39 year old man who manifested a severe phobic reaction with associated anxiety, palpitation, fear of being alone, and agitation of one year's duration. Librium therapy (25 mg. before meals and at bedtime) was begun. After one week the patient showed marked improvement and has continued to do well. He is eating and sleeping better, is less tense and agitated, and is able to be alone and carry on his work. There have been no side effects.

Case 7

This patient, a 40 year old woman, had been suffering from an anxiety reaction, with depression, nervousness, tenseness, and complaints of generalized numbness, for the past three years. She had had osteomyelitis of the pelvic bone for the past 16 years. She was started on 25 mg. of Librium three times a day, and began to improve after about 10 days. During the four months that this treatment has been continued, the symptoms have diminished steadily. She is less tense and anxious, and no longer depressed. Anorexia and insomnia have ceased to be problems. No side effects have been noted.

Case 20

A 46 year old woman was found to have a manic-depressive reaction with restlessness, overactivity in both mental and motor areas, overtalkativeness, and so forth. She had a history of manic-depressive episodes for the past 10 to 12 years, on three occasions requiring hospitalization and electroshock treatments. Nearly all the tranquilizing drugs had been tried in this patient, and the referring physician noted that she became more excited on every one. Barbiturates and other sedatives also had an exciting effect. Twenty-five milligrams of Librium before

meals and at bedtime was prescribed, and within 48 hours she had calmed down and was much more manageable and less hyperactive. She was able to participate in group activities. Medication is being continued, and at present it seems possible to avoid the use of electroshock therapy. The patient has shown no adverse side effects.

Case 22

This 24 year old man was diagnosed as having an acute anxiety reaction with severe nervousness, anxiety, tension, agitation, and insomnia of six weeks' duration. Within four days of the institution of Librium therapy (25 mg. before meals and at bedtime) symptomatic improvement was noted and has been maintained. The patient has been able to return to work, and is sleeping and eating better. Side effects: none.

Case 31

A 52 year old woman had a severe anxiety reaction with associated nervousness, tenseness, and pain in the neck and back of four years' duration. She had been hospitalized a number of times without real benefit. The blood count and urinalysis were normal. Since beginning to take Librium (25 mg. three times a day), the patient is steadily improving. After two months of therapy she is able to do her housework and carry on normal activities. Treatment is continuing.

Case 36

The diagnosis in this 27 year old male was anxiety reaction with obsessive-compulsive features. For the previous eight months he had suffered from headaches and tension. After receiving 25 mg. of Librium three times a day for one week, he showed great improvement and continued to improve when the dosage was reduced after three weeks to 25 mg. twice daily. No side effects were noted.

Comment

It should be emphasized that these patients, because of the severity of their condition, were given 25 mg. capsules instead of the 10 mg. doses prescribed by some psychiatrists for ambulatory patients. Despite the larger daily dosage (75 mg.) there was only one side effect of significance: 8 women patients reported loss of libido. This effect, as well as increased sexual desire, has been encountered by other investigators who also were employing relatively high dosages³.

Blood and urine tests showed no significant change.

One patient reported constipation. Another, a 59 year old woman who had chronic free-floating anxiety of several years' duration, had been hospitalized numerous times and treated by various methods with no relief. The usual dosage of 25 mg. before meals and at bedtime was prescribed. After three days she complained of oversedation and refused to continue the drug, although a reduced dosage was suggested.

Two of the three patients with depressive reactions failed to respond, as did the 29 year old woman with schizophrenia, who was also mentally defective. A male patient aged 36, with obsessive-compulsive reaction marked by severe anxiety and depression, became worse after six days of medication and the drug was discontinued.

Response to Librium was apparent within a few days after therapy was initiated, and once improvement began it was continued. More than half the group under study had suffered from anorexia and insomnia, and some were underweight. As anxiety and tension lifted, these patients began eating and sleeping better, and those

who were underweight gained needed pounds. While the reduction of anxiety was the conspicuous feature, the concomitant symptoms were also relieved: phobias decreased and patients were able to be alone, go out in a car, do their housework, or resume jobs they had been too ill to cope with. Some reported that they were "thinking better," an effect frequently mentioned in the literature.

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Treatment of Female Inebriate Patients at Dorothea Dix Hospital

R. L. ROLLINS, M.D.*

RALEIGH

Many patients come to the hospital with erroneous ideas regarding admission procedures, length of stay, medication, ward facilities, visiting privileges, and results of treatment. It is hoped that the following description of the treatment program at Dorothea Dix Hospital, Raleigh, North Carolina, will be helpful to physicians, prospective patients, and their relatives.

Eligibility and Length of Hospitalization

Any female resident of North Carolina is eligible for treatment under this program. Admissions are voluntary or by commitment for alcohol or narcotic addiction. Commit-

ment papers must be signed by two physicians and the clerk of Superior Court. Prior to admission, the date of admission must be arranged with the hospital administrative officer.

Prepayment of \$75.00 per month is required. In indigent cases, this expense is assumed by the county of legal residence. Alcoholic patients and voluntary drug patients remain 30 days, and legally committed narcotic and barbiturate patients 60 days. Patients are released early only in cases of extreme emergency. Families and physicians frequently request that hospitalization be prolonged because resumption of antisocial behavior seems likely. There is no provision for patients to remain beyond their routine stay on this basis. No visitors

*Formerly Staff Psychiatrist, Dorothea Dix Hospital, Raleigh, North Carolina. Present address, United States Air Force Hospital, Maxwell Air Force Base, Alabama.

other than the family pastor and physician are allowed.

Physical Environment

One wing of Hoey Building, with a capacity of 25 beds, is available for this program. There is an eight-bed ward, three four-bed rooms, and five private rooms. A small sitting room and a porch complete the area. The building is locked and patients are served meals in the building. They go out only when accompanied by personnel. One nursing assistant is assigned to the Inebriate Section on the day shift and two nursing assistants on the evening and night shifts (these two must also care for 75 mental patients.)

Treatment

A physical examination is done and a brief history obtained on the day of admission. A hemoglobin determination, white blood cell count, serologic test for syphilis, and urinalysis are also done. Severely ill patients are sent to the medical service.

Routine medication for alcoholics is paraldehyde, 10 cc. given every four hours the first day, every six hours the second day, and every eight hours the third day. Tranquilizing drugs are prescribed, if necessary for approximately 10 days. An effort is made to avoid use of tranquilizers after this period. Antabuse is not used.

Barbiturate addicts are withdrawn over a 10-day period on gradually decreasing amounts of the addicting drug. Narcotics are withdrawn over a 10-day period, with decreasing doses of morphine and methadone (patients receiving narcotics remain on the medical ward), except that Demerol is used for Demerol addicts. Many addicts, however, are able to discontinue drugs abruptly. Paregoric and codeine addicts are not given narcotics. Both narcotic and barbiturate addicts usually receive anticonvulsive and tranquilizing drugs during the withdrawal period.

Patients are seen by the ward physician each morning. An effort is made to inter-

view each patient at least once. Patients with more specific psychologic problems may be seen more often in individual interviews, but psychotherapy is not available. The physician on night call visits the ward briefly each evening. Diagnostic medical studies and surgery are not done except in cases of emergency.

Movies, church services, and occupational therapy are available once weekly. Walks and visits to the canteen are scheduled daily if sufficient personnel is available. There is a television set on the ward, but patients do complain frequently of boredom.

Representatives from a local group of Alcoholics Anonymous visit the ward each Sunday, and patients may attend these meetings if they choose. The hospital chaplain visits the ward frequently.

Result

No studies of results are available. About half the patients, however, are not readmitted within one year. What happens to this group is unknown. Presumably some have less difficulty with their drinking or drug problem. Of the half requiring readmission within one year, many abstain from alcohol or drugs for a few months and then relapse. Frequently, though, patients are intoxicated or taking drugs before reaching home.

Summary

The admission procedure, medical care, and ward environment for female alcoholic and narcotic patients at Dorothea Dix Hospital, Raleigh, North Carolina is described. This program offers 30 days of enforced sobriety for alcoholics and approximately 50 days without drugs for committed addicts. About half the patients are not readmitted within one year of release, but their course is unknown. About half return to alcohol or drugs immediately or within a few months.

The assistance of Mrs. Ellen Barlett, R.N., Dr. David Fuller, Clinical Director, and Dr. Walter Sikes, Superintendent, in preparing this article is gratefully acknowledged.

Report from The Duke University Poison Control Center

JAY M. ARENA, M.D., *Director*

Mineral Seal Oil

In recent months the Duke Poison Control Center has had several requests for information regarding red furniture polish. The ingestion of this agent has produced serious and prolonged pneumonitis and at least one death in the past few months. With this fact in mind the following discussion on mineral seal oil, the offending petroleum distillate in red furniture polish, is being reported.

This petroleum oil is obtained as a fraction of distillate from crude petroleum in the range of 500 to 700 F. The relative composition of a particular mineral seal oil will vary with the source of the crude petroleum. This refined petroleum hydrocarbon contains unsaturated and saturated aliphatic and aromatic hydrocarbons. The unsaturated aliphatic hydrocarbons are largely removed by acid washings. The resulting product is composed principally of saturated aliphatic hydrocarbons of a higher molecular weight than those characteristic of gasoline and kerosene. It also contains some cyclic and branched chain compounds.

Since mineral seal oil is a heavier "cut" than the gasoline-kerosene fraction, it is more nearly similar to a light lubricating oil, and is used especially in furniture polishing agents. Variable products of red furniture polish may contain from 20 to 99 per cent mineral oil. To this hydrocarbon base less than 1 per cent by volume of various odorizing and coloring agents are added, such as oil of cedarwood, cedar leaf, turpentine, camphor, lemon, wintergreen (methyl salicylate) and traces of aniline dye. Kerosene is added to the products with less mineral seal oil.

The morbidity and mortality from poisoning with this compound is of far greater severity than that usually associated with

the more commonly observed kerosene intoxication. The systemic symptoms are more severe, with drowsiness, lethargy, high spiking temperatures of two or three weeks duration, and rather pronounced extensive pneumonitis disclosed both by physical examination and x-rays. Resolution may require from three to six weeks. Emphysema is not uncommon as part of the pneumonic picture, and pneumothorax has occasionally been reported.

Several possibilities may in whole or in part be the factors involved in this more critical clinical course. Since mineral seal oil is a light lubricating oil it might act both as a pulmonary irritant and as a foreign body in the lung, thus giving signs and symptoms similar, in some respects, to both kerosene (chemical) pneumonitis and lypoid pneumonia. Thus the pulmonary irritation is compounded. Another factor undoubtedly is that larger amounts of this product are ingested. Red furniture polish is sold in an attractive container, is brightly colored and slightly flavored, and, though flat, is not unpleasant to the taste. Kerosene on the other hand, because of its viscosity, pungent odor and acrid taste, is seldom taken in any great quantity. A third factor which may contribute to the severity of the pneumonia would be the presence of small quantities of coloring and odorizing agents in most of these agents.

The treatment is similar to that of petroleum distillate and kerosene poisoning, as discussed in the November, 1960, issue of this JOURNAL. However, because of the greater potential for pulmonary complications resulting from aspiration, the stomach should never be emptied by gagging or by giving an emetic. Gastric lavage should be done, if at all, only when unusually large amounts are ingested and the risk of producing vomiting during the procedure would be minimal, such as in an older child or adult. Particular effective in this group would be the use of a corticosteroid as an anti-inflammatory agent, in addition to antibiotics and other supportive therapy (Croupette, Isolette, etc.).

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MAY, 1961

A NEEDLESS TRAGEDY

Some form of shock therapy is often effective in bringing an individual literally to his senses and helping him solve a disturbing problem. There are times when a severe shock may cause a community to realize that something is wrong with society's attitude toward a problem. The citizens of Winston-Salem and Forsyth County were given such a shock when a brilliant young doctor from Thailand was killed by an irresponsibly reckless driver racing with an equally irresponsible one. Dr. Anekamaya was a trainee at Bowman Gray under the Cardiovascular Training Program sponsored by a grant from the United States Public Health Service. By July 1 he would have completed his training. Since he was only 31 years old, he

should have been able to look forward to a long and useful life of service. As it is, his widow and 5 month old baby had to go back without him. One wonders just what she will have to say her husband's untimely death.

An editorial in the *Winston-Salem Journal* for March 1 says so well what needs to be said that it is reproduced in full with permission.

HARD TO UNDERSTAND

And we wonder why people in other countries don't understand America and Americans . . .

How could the people of Thailand, for instance, understand what happened on Highway 421 Monday afternoon? It was a warm, sunshiny day; the highway, wide and smooth; the automobile the doctor was driving, only about three years old. Yet, for all the favorable driving conditions and for all the marvels of modern transportation in America, an innocent driver, Dr. Sudhawit Anekamaya, lost his life.

Because he was himself a Thai, his countrymen will be all the more moved to try to understand how it could have happened. And because in their country concrete highways and high-powered automobiles are rare, it will not be easy to explain how two cars, allegedly racing for the fun of it, came barreling down the highway in the opposite direction, and how one of them, according to witnesses, veered across the center line and headon into the doctor's car.

Even so, how it happened will be easier for them to comprehend than why. Why do cars in America race on a busy highway? Why are innocent drivers like the doctor subject to the hazards of racing? Why does America permit it? Are there not laws?

This the people of Thailand cannot understand. And we can't expect them to—not when obviously we don't or won't fully understand it ourselves.

We abhor racing on the highways, to be sure. We have passed laws prohibiting it. But cars continue to race. Persons, like Dr. Anekamaya and his companion, continue to be killed or injured. Drivers, like those Monday who are charged with the crime of racing, will be allowed to keep right on driving until their trial comes up. Obviously we haven't backed our words with a strong enough law. Obviously the courts haven't backed the law with strong enough judgements.

In this shortcoming, as on the highway, Dr. Anekamaya was innocent. He was a visitor in this country with no voice either in the making or in the enforcement of our laws. His mission was simply to taste some of the medical knowledge in this highly developed country that he might minister better to the people of his own

less fortunate country. His death therefore is all the more tragic. His country has lost a doctor. This country has lost, in him, an avenue by which the people of Thailand might better understand America.

Thailand will not be able to understand why it could have happened. But we must understand, and make sure that it doesn't happen again. Unlike Dr. Anekamaya, we have a voice in the laws and the enforcement thereof. In the shame of his death, let that voice be raised.

* * * * *

MOBILE OUTLAWS HIGH HEELS

In the Winston-Salem *Sentinel* for April 10, Professor Robert E. Lee of the Wake Forest Law School quotes an ordinance recently passed by the Board of Commissioners of Mobile, Alabama:

Section 1. That the wearing of shoes with heels which measure more than one and one-half inches in height and less than one inch in diameter on the wearing surface upon the public streets of the City of Mobile is hereby prohibited.

Section 2. Any person desiring to wear shoes in excess of the limitations set out in section one above may do so by obtaining a permit from the City of Mobile and by agreeing that upon the issuance of such permit that they thereby relieve the City of Mobile from any and all liability for damages to themselves or to others caused by their falling upon the public streets or sidewalks of the City of Mobile while wearing such shoes.

In his comment Dr. Lee disapproves the ordinance:

Since high heeled shoes have become accepted as part of a woman's attire, cities, rather than barring their wear, ought to provide that they may be worn safely.

When the automobile replaced the horse and buggy, we built wider and better paved highways. Now that the spiked or high-heel shoe has arrived, should we not have more defect-free pavements for sidewalks? If the women have expressed a preference for this type of shoe and the men a desire to see them so attired, the city should not hinder but provide for the trend.

For at least three reasons this JOURNAL would like to offer a dissenting opinion from Dr. Lee's opinion and applaud the wisdom of the Mobile Commissioners. First, it is extremely doubtful that even a majority of women have expressed a preference for this type of shoe. Women, far more than men, are literally the slave of fashion. If Dr. Lee will talk to a representative group of

women, it is quite probable that he will find that a large proportion, if not a majority, dislike the high-heeled, sharp-toed shoes, but say, "I can't find anything else to wear."

Second, it is extremely doubtful that a majority of men desire to see their feminine relatives and friends so attired. Certainly, an overwhelming majority of medical men do not—unless it be the orthopedists, one of whom said the shoe manufactures were his best friends because they send him so many patients.

Third, the analogy of replacing dirt roads with paved highways to accommodate automobiles and of repaving our present sidewalks to accommodate a transient change in the style of shoes seems far-fetched. Just what material could be used that would withstand the repeated impact of a steel-tipped heel, a half inch or less in diameter, worn by a 200-pound woman? With all due respect to Dr. Lee, this JOURNAL expresses the hope that enough cities will follow Mobile's example to force the shoe manufacturers back to making shoes that are comfortable as well as good looking.

Since this editorial was written, other dissenting opinions appeared in the popular syndicated column of Mrs. Abigail Van Buren (known as "Dear Abby" to thousands of readers). Mrs. Van Buren stated that she had received literally thousands of letters approving a column she had written recently protesting against the senseless fashion of high heels. It is gratifying to know that this JOURNAL has such strong support.

* * * * *

MENSTRUATION AND ACCIDENTS

The *British Medical Journal* for November 12 contains an excellent example of clinical research by a general practitioner¹. Dr. Katherine Dalton was impressed by the number of women involved in accidents during or within 4 days before menstruation. Recalling that in 1934 Whitehead had noted that some air accidents occurred in women pilots during their menstrual period, she kept a record of women admitted to accident wards of 4 London hospitals which she visited regularly. She also included women in her own medical practice who had accidents.

Of 124 women involved in accidents, 84 had been menstruating regularly. Of these, 44 (52 per cent) were either menstruating or were due to menstruate within 4 days. Twenty-six of the non-menstruating women were menopausal — 17 natural, 9 artificial. This was an unduly high proportion of accident-prone women who had had an artificial menopause.

Dr. Dalton's conclusion was that premenstrual lethargy and irritability probably accounted for the high proportion of accidents. These findings, she says, "cause one to consider the wisdom of administering tranquilizers for premenstrual tension, since they may increase accident-proneness at the most dangerous time of the menstrual cycle."

One final comment may be pertinent. Since water retention is commonly considered a major factor in premenstrual tension, should not a non-tranquillizing oral diuretic, such as chlorothiazide or one of its modifications, be given a trial?

Reference

1. Dalton, K.: Menstruation and Accidents, Brit. M.J. 2: 1425 (Nov. 12) 1960.

* * * * *

RENASCENCE OF THE ROCKING CHAIR

Recently the newspapers have told us that President Kennedy, with the approval of his personal physician, Dr. Janet Travell, relaxes in an old-fashioned rocking chair. When Dr. Travell was asked about it, she said more than five years ago the President had found the rocking chair in her office so comfortable that he asked her to get one just like it for him. She told the Associated Press that the rockers were made in North Carolina and that she had ordered a number of them for patients in all parts of the country. She thought it would not be ethical to

tell where the rockers were purchased but that anyone interested could write her at the White House. She was, of course, deluged with letters of inquiry. Naturally the secret leaked out that the chairs were made in Asheboro by the P & P Chair Company.

According to Dr. Travell, the rocking chair has many advantages over the straight or still chair: "Such a chair," she said, "provides gentle constant exercise and helps prevent muscular fatigue."

No doubt we may expect a boom in the sale and use of the old-fashioned rocking chair. It is gratifying to know that North Carolina scores another triumph in the renaissance of the rocker.

* * * * *

HARNETT AND PERSON COUNTIES RECOGNIZED IN P.R. DOCTOR

The March issue of the A.M.A. Communications Division publication, *P.R. Doctor*, is of particular interest to North Carolina. Almost a page is devoted to a feature article on the cooperation between the Harnett County Medical Society and the County Welfare Board whereby welfare applicants are examined by a three-man committee from the Medical Society the fourth Friday of every month. As a result of careful screening of medical records, 30 recipients of county welfare checks were removed from the welfare rolls—saving the taxpayers of the county approximately \$1,380 monthly. The system insures every applicant a careful medical examination at no cost to himself and also results in a great saving of time for the individual physicians.

A half column was devoted to the home care project in Person County, sponsored by the District Health Department and the North Carolina State Board of Health.

It is good to know that what is done in these two North Carolina counties is given such wide recognition.

Bulletin Board

COMING MEETINGS

Pitt County Medical Society and the Pitt County Mental Health Clinic in cooperation with the Department of Psychiatry, Duke University Medical Center, Postgraduate Course on "Psychiatry for the Non-psychiatrist"—Pitt County Mental Health Clinic, Greenville, Thursday evenings through June 15.

North Carolina Heart Association, Annual Meeting and Scientific Session—Robert E. Lee Hotel, Winston-Salem, May 24.

Seaboard Medical Association of Virginia and North Carolina, Annual Meeting—The Carolinian Hotel, Nags Head, June 16-18.

Mountaintop Medical Assembly—Waynesville, June 22-24.

Duke Medical Postgraduate Course—Morehead Biltmore Hotel, Morehead City, July 16-22.

Southern Obstetric and Gynecologic Annual Seminar—Grove Park Inn, Asheville, July 17-22.

Tri-State Medical Association of Virginia and the Carolinas, Annual Meeting—Cavalier Hotel, Virginia Beach, Virginia, July 27-28.

American Medical Association, Annual Meeting—New York City, June 26-30.

Trudeau School of Tuberculosis and other Pulmonary Diseases, Forty-sixth Annual Session—Saranac Lake, New York, June 5-23.

Animal Care Panel—Boston, Massachusetts, September 27-29.

NEW MEMBERS OF THE STATE SOCIETY

The following physicians joined the Medical Society of the State of North Carolina during the month of March.

Dr. James Barker Raymer, 225 Hawthorne Lane, Charlotte; Dr. Wesley Scott Garland, 109 N. Elm Street, Marshville; Dr. John Charles Doerr, 621 W. Jones St., Raleigh; Dr. Thomas Edison Castelloe, 1313 Daniels St., Raleigh; Dr. Donald Vance Chamblee, Broadway; Dr. Shelton Miller, Jr., 920 Goodwood Rd., Winston-Salem; Dr. James Warren Wideman, 805 N. Thompson St., Whiteville; Dr. Stephen Cornelius Pugh, Chadbourn Medical Center, Chadbourn; Dr. Hewlett Collier Connell, Wendell;

Dr. Alexander Canaday McLeod, New York Hospital, Box 161, 525 East 68th St., New York 21, New York; Dr. John Plummer Holt, 219 Southside Ave., Asheville; Dr. Sarah Alice Taylor Morrow, Guilford County Health Department, High Point; Dr. Henry Abernethy, 1140 16th St., N.E., Hickory; Dr. Charles Trado, 21 2nd Avenue, N.E., Hickory; Dr. Lee Seagle, 219 N. Center St., Hickory; Dr. Aulsey Lee Denton, Jr., 1110 Wake

Forest Rd., Raleigh; Dr. Thomas Bywater Greer, 714 St. Mary's St., Raleigh; Dr. Francis Edward Winslow, Jr., 817 Hillsboro St., Raleigh;

Dr. Charles L. Johnson, Jr., Box 817, Chapel Hill; Dr. Jesse Robinson Hicks, 1350 Kings Drive, Charlotte 7; Dr. Presley Zachary Dunn, Jr., 942 Davie Ave., Statesville; Dr. George Morgan Eckley, Jr., 644 Cherry St., Statesville; Dr. Tiffany Nolan Barnes, 533 S. Fayetteville St., Asheville; Dr. Thomas Rector Bass, 2125 Fayetteville, Clayton; Dr. James Henry McCallum, Jr., 202 E. Liberty St., Williamston; Dr. Emmett Royce White, Valdese Gen. Hosp., Valdese; Dr. Cornelius Theodore Patrick, 120 Washington St., Washington; Dr. Evan Charles Fowler, Cherry Hosp., Goldsboro; Dr. Bryan Clinton West, Jr., 206 S. Road St., Elizabeth City; Dr. Robert Thomas Schorr, 403 W. Church St., Elizabeth City; Dr. Thomas Robert Acklen, Jr., 427 Charlotte St., Roanoke Rapids, and Dr. Leo Clayton McCampbell, 907 Monroe St., Roanoke Rapids.

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

The Duke University Medical Center's annual summer postgraduate course will be held July 17-22 in Morehead City.

Dr. William M. Nicholson, assistant dean of the Duke Medical School in charge of postgraduate education, announced plans for the course, which will provide refresher work for physicians and help them keep abreast of new developments in medicine.

Serving on the faculty will be Drs. Walter L. Floyd, Henry D. McIntosh, John V. Verner and and Dr. Nicholson, all of the Medical Center's department of medicine; Drs. William J. A. DeMaria, Madison S. Spach and Robert S. Stempel, all of the pediatrics department; Dr. W. Glenn Young Jr., surgery department; and Dr. Joseph K. Isley, radiology department.

The course is approved for 30 hours of postgraduate education, Category 1, required by the American Academy of General Practice.

Information concerning the course can be obtained by writing to the Director of Postgraduate Education, Duke University Medical Center, Durham.

* * *

Dr. Kenneth L. Duke, associate professor of anatomy, is conducting research in Malaya as this year's recipient of the Alan Gregg Travel Fellowship in Medical Education.

Dr. Duke was selected for the honor by the China Medical Board of New York.

The Board makes one such award each year to enable an American medical school faculty member to undertake study in the Far East that will increase his effectiveness as a medical educator. Selection is based on past accomplish-

ments and promise to fulfill the purpose of the fellowship in promoting medical education.

* * *

Richard M. Conover, supervisor of inhalation therapy at the Duke University Medical Center, has been appointed chairman of the safety committee of the American Association of Inhalation Therapists.

* * *

Dr. Ivan W. Brown Jr., professor of surgery, has been named an alumni member of Phi Beta Kappa, national scholastic honorary fraternity.

Alumni elections are made in recognition of outstanding achievement in science, literature or education.

A 1940 Duke Medical School graduate, Dr. Brown is known for his research dealing with blood preservation and with the use of hypothermia (low body temperature) in heart surgery.

* * *

Congressman John E. Fogarty (D-R-I), a nationally known leader in health legislation was guest speaker for the 1961 meeting of the Southern Association of Medical Schools and Teaching Hospitals, held in Durham, April 9-10. He spoke on the theme for the meeting, "Financing Medical Education."

* * *

Dr. Hans Lowenbach, professor of psychiatry at the Duke Medical Center, is giving a series of 12 weekly lectures in Greenville, North Carolina, for family doctors and medical specialists of Pitt County.

The course is part of a new program designed to provide training in psychiatry for physicians "without the necessity of each doctor traveling to a psychiatric training center."

* * *

Duke University has received a March of Dimes grant of \$25,027 to conduct educational research in interdisciplinary teaching, research and patient care.

The studies will center on methods of encouraging and promoting collaborative efforts among the medical and surgical specialties and the physical therapy department.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Dr. Kenneth M. Brinkhous, chairman of the Department of Pathology in the School of Medicine, won the O. Max Gardner Award recently as the member of one of the faculties of the Consolidated University of North Carolina who during the current scholastic year "has made the greatest contribution to the welfare of the human race."

Dr. Brinkhous is an international authority and research specialist in hemophilia, the rare bleeding disease. Research findings in relation to hemophilic dogs at Chapel Hill are being

related to facets of a number of diseases associated with bleeding.

* * *

Dr. James W. Woods Jr., associate professor in the University of North Carolina School of Medicine, has been recommended for a leave of absence from June 1 through December 31, 1961, to serve as Visiting Professor at the University of Sao Paulo, Brazil.

* * *

For the second consecutive year a student of the University of North Carolina School of Medicine has been awarded a fellowship to serve and study in one of the world's underdeveloped nations.

Robert L. Browning Jr., a third year medical student, and son of Mr. and Mrs. R. L. Browning of Monroe, will spend 11 weeks at one of the five Baptist Mission Hospitals in Nigeria, West Africa.

* * *

Twelve persons from West Berlin, Germany recently inspected the University of North Carolina School of Medicine and N. C. Memorial Hospital.

The group, which is connected with a new medical research and training center in West Berlin was on a 30-day visit to leading American medical centers.

* * *

Appointments and promotions in the U.N.C. School of Medicine faculty were announced by Chancellor William B. Aycock recently.

Dr. Wayne Henry Akerson, assistant professor of surgery, School of Medicine resigned January 31 to enter private practice.

Effective as of July 1, Dr. Gustin Thomas Kifney Jr., clinical instructor in the School of Medicine, will become assistant professor.

As of this past February 1, Dr. Marianne S. Breslin, formerly a clinical instructor in the School of Medicine, has been named to the position of instructor.

A one-year appointment as instructor in the Department of Psychiatry, School of Medicine, beginning July 1, has been made to Dr. Rex Wilson Speers, Dr. Speers is currently a resident in the School of Medicine.

* * *

Dr. Ralph L. Dunlap, chief of the Child Psychology Section at the North Carolina Memorial Hospital, presented a paper, "Long Term In-Patient Treatment of Severely Disturbed Children," at a symposium during the annual meetings of the Southeastern Psychological Association held in Gatlinburg, Tennessee, April 13-15.

* * *

The fifth Southern Regional Institute on Recreation in Hospital was held at the University of North Carolina, April 20 and 22. Harold D. Meyer, head of the University Division of Recreation, was the director of the institute. He was assisted by Frances Cleary, recreation di-

rector, Department of Psychiatry, and Assistant Professor H. Douglas Sessome of the Department of Sociology and Anthropology.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Nine papers prepared in departments of the Bowman Gray School of Medicine were presented in early April at meetings of the Federation of American Societies for Experimental Biology held at Atlantic City, New Jersey.

Dr. Thomas B. Clarkson, associate professor of experimental medicine, presented two papers: "Effects of Dietary Fats, Protein and Cholesterol on Coronary Atherosclerosis in Pigeons," and "Graduate and Professional Training in Laboratory Animal Care."

Dr. Harold D. Green, Gordon Gray Professor of Physiology and Pharmacology, presented a paper entitled "Simultaneous Determination by Dye Measurements of Vascular Volume and Conductance in the Dog's Paw." Dr. Green also presided over a session on peripheral circulation and participated in a symposium on "Pressure-Flow Relationships in Various Vascular Beds" presented by the circulation section of the American Physiology Society.

Dr. J. Maxwell Little, professor of pharmacology presented "Cardiovascular Effects of Chronic Partial Carotid Sinus Compression in Dogs."

Dr. J. Richard R. Bobb, associate professor of physiology and pharmacology, presented "Tissue Hypoxia and Cardiovascular Function in Dogs." Dr. Carlos E. Rapela, associate professor of physiology and pharmacology, presented "Cerebral Venous Blood Flow."

Three other papers, prepared by trainees in the medical school's cardiovascular training program, were presented also.

* * *

Dr. William H. Boyce, professor and chairman of the Section on Urology, participated in a panel discussion of the "Surgical Management of Hydronephrosis" during sectional meetings of the American College of Surgeons, March 6 to 9, at Philadelphia. At the same meetings, Dr. Louis De S. Shaffner, assistant professor of surgery, spoke on "Modern Management of Suppurative Disease of the Lung and Pleura."

Dr. Fred K. Garvey, professor of urology, was moderator of a panel discussion of pediatric urology at meetings of the Southeastern Section of the American Urological Association, March 19 to 24, at Hollywood, Florida. At the same meeting, Dr. Clifford N. Edwards, research instructor in urology, narrated the "Advances in Surgery of Renal Calculi," a movie prepared by the section on urology and and the department of medical illustrations.

Dr. Donald M. Hayes, assistant dean in charge of admissions and premedical relations, and instructor in medicine, presented "Correlative Studies of the Chemotherapy of Mouse and Human Myeloma" at a meeting of the American Association for Cancer Research, April 9, at Atlantic City, New Jersey. The paper was prepared by Drs. Hayes; Charles L. Spurr, professor of medicine; and John Hines, assistant resident in medicine.

* * *

An Introduction to the Experimental Method, a book by Dr. J. Maxwell Little, professor of pharmacology and associate professor of physiology, has been published by the Burgess Publishing Co. of Minneapolis.

* * *

Two papers prepared by members of the Department of Anatomy were read at the annual meeting of the American Association of Anatomists, March 21 to 24, at Chicago. Dr. Charles E. McCreight, assistant professor of anatomy, presented "Hyperplasia in Renal Epithelium Following Partial Removal of the Kidneys." The paper was prepared by Dr. McCreight and Dr. Norman M. Sukin, William Neal Reynolds Professor of Anatomy. Graduate student Russel J. Reiter presented "The Effect of Excess Vitamin A on Estrogen Induced Uterine Metaplasia," a paper co-authored by Reiter and Dr. Walter J. Bo, associate professor of anatomy.

EDGECOMBE-NASH MEDICAL SOCIETY

The regular meeting of The Edgecombe-Nash County Medical Society was held in Rocky Mount on April 12.

Mr. N. A. Avera of the local Social Security office introduced Dr. Helen Hall, who in turn presented and discussed a film, "**The Disability Decision**," which concerns evaluation of claimants for Social Security on the basis of disability.

FORSYTH COUNTY MEDICAL SOCIETY

The Forsyth County Medical Society held its regular meeting in Winston-Salem, on April 6, at the Old Town Country Club. Dr. Walter Hollander, assistant professor of medicine of the University of North Carolina School of Medicine spoke on "Potassium Problems in Clinical Medicine."

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

Applications for certification in the American Board of Obstetrics and Gynecology, new and reopened, Part 1, and requests for re-examination in Part 11 are now being accepted. All candidates are urged to make such application at the earliest

possible date. Deadline date for receipt of applications is August 1, 1961. No applications can be accepted after that date.

Candidates are requested to write to the office of the Secretary for a current Bulletin if they have not done so, in order to be well informed as to the present requirements. Application fee (\$35.00), photographs, and lists of hospital admissions must accompany all applications.

After July 1, 1962, this Board will require a minimum of three years of approved progressive residency training to fulfill the requirements for admission to examination. After the above date, training by preceptorship will no longer be acceptable.

Diplomates of this Board are urged to notify the office of the Secretary as soon as possible of changes in address.

Office of the Secretary
Robert L. Faulkner, M.D.
2105 Adelbert Road
Cleveland 6, Ohio

ARTHRITIS AND RHEUMATISM FOUNDATION

Development in the treatment of gout during the past decade have made this severely painful and crippling form of arthritis one of the most successfully controlled, even though no cause or cure has yet been found, according to an article in the Arthritis & Rheumatism Foundation's **Bulletin on Rheumatic Diseases**.

Of the 11,000,000 arthritis victims in the nation, an estimated half-million have gout, reports the Foundation. By far the greatest number are men.

TRUDEAU SCHOOL OF TUBERCULOSIS AND OTHER PULMONARY DISEASES

The Trudeau School of Tuberculosis and Other Pulmonary Diseases, which will hold its forty-sixth session in Saranac Lake, New York from June 5 to 23, continues to provide a unique opportunity for training in the field of chest diseases. This annual postgraduate course for physicians, conducted under the auspices of the Trudeau Foundation and supported by the Hyde Foundation, is able to provide outstanding instruction at a minimal tuition of \$100.00 for a three weeks' session. Attendance at the Trudeau School carries with it a thorough review for specialization in pulmonary disease or for work in public health involving tuberculosis.

The enrollment is necessarily limited, and therefore application should be made early. A few scholarships are available for those who qualify.

Inquiries should be addressed to the Secretary, Trudeau School of Tuberculosis and Other Pulmonary Diseases, Box 670, Saranac Lake, New York.

NATIONAL SOCIETY FOR CRIPPLED CHILDREN AND ADULTS

Crippled children and adults will have more fun camping this summer. More than 50 new resident camps and a substantial increase in the number of day camp programs are revealed in the revised edition of "Directory of Camps for the Handicapped," just published by the National Society for Crippled Children and Adults, the Easter Seal Society.

Prepared by the National Society under joint sponsorship of the American Academy of Pediatrics and the American Camping Association, the directory supplies up-to-date information of approved camping programs and facilities from which parents of handicapped children, professional workers, and crippled persons can select programs. Some 250 resident camps and more than 100 day-camp programs are listed.

The "Directory of Camps for the Handicapped" is available through the National Society for Crippled Children and Adults, 2023 West Ogden Avenue, Chicago 12, Illinois. The price is 50 cents per copy.

ANIMAL CARE PANEL

Boston will be the site of the Annual Animal Care Panel Meeting, September 27, 28, 29, 1961. The ACP is an organization of individuals professionally engaged in the production, procurement, care, management and use of laboratory animals and of institutions interested in these areas of research and animal care.

The American Board of Laboratory Animal Medicine, the Laboratory Animal Breeders' Association, and the Allied Trade Association will hold simultaneous sessions at the meeting.

MANUFACTURING CHEMISTS' ASSOCIATION INC.

Physicians interested in accurate and up-to-date information on food additives will find this data in a new reference handbook prepared by the Manufacturing Chemists' Association.

"Food Additives: What They Are—How They Are Used" is a basic reference book which covers many aspects of food additives, presenting technical information in popular, readable language.

Requests for single copies of this publication will be honored without charge when received from individuals on institution or organization letterhead. Address requests to: Manufacturing Chemists' Association, Inc., 1825 Connecticut Ave., N.W., Washington 9, D. C.

PASSANO FOUNDATION AWARD

The Board of Directors of the Passano Foundation announces that Doctor Owen H. Wangenstein has been selected as the recipient of the \$500 Passano Award for 1961.

On Wednesday evening, June 28, during the convention of the American Medical Association in New York City, a reception and dinner will be held at the Statler-Hilton Hotel to honor Doctor Wangenstein.

The Passano Foundation is sustained by annual contributions from The Williams & Wilkins Company, publishers of books and periodicals in medicine and the allied sciences.

NATIONAL ASSOCIATION OF BLUE SHIELD PLANS

Enrollment in the nationwide Blue Shield Plans surpassed the 47,000,000 member mark at the end of 1960, the National Association of Blue Shield Plans reported in Chicago recently. Total membership in the 74 medical-surgical Plans reached 47,084,988 on December 31, 1960, representing an enrollment of one out of every four Americans, and nearly 15 per cent of the total Canadian population.

VETERANS ADMINISTRATION

Major changes in hospital design will be incorporated in the Veterans Administration's 12-year, \$900,000,000 program for modernization and replacement of its obsolescent hospitals, the VA

Chief Medical Director, Dr. William S. Middleton, said today.

The trend is away from special hospitals for psychiatric and tuberculous patients and toward the general hospital, which can care for these patients as well as general medical and surgical patients.

* * *

Seven of the nation's top medical leaders will advise the Veterans Administration on its nationwide medical research program, as members of the newly constituted VA Research Advisory Committee. Among them is Dr. Eugene A. Stead, chairman of the Department of Medicine at Duke University School of Medicine.

* * *

The Veterans Administration has gained the equivalent of nearly four 600-bed mental hospitals, at no cost to the taxpayer, through placement of recovering mental patients in foster homes during the past ten years.

The VA said 2,375 mental patients from its hospitals lived with "adopted" families in private homes near the hospitals during calendar year 1960. This is a 22 per cent increase over the number in foster homes in 1959 and more than twice as many as in 1956.

Patients are carefully selected by VA doctors and the foster parents and homes are screened by VA social workers.



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New Film on Project HOPE

A story of medical training and teaching in Southeast Asia is depicted in a new and dramatic 27-minute color motion picture documentary made available by Project HOPE. The film, "Voyage of the SS HOPE," tells the story of the American people's floating medical center currently in Indonesia.

The story is that of the SS HOPE I, a former U. S. Navy hospital ship converted to a floating medical school through the contributions of the American people. The SS HOPE is the principal vehicle of the People-to-People Health Foundation, Inc., 1818 M Street, N. W., Washington 6, D. C.

The documentary is available for interested groups and television showings. Inquiries may be directed to: Film Department, Project HOPE, 1818 M Street, N. W., Washington 6, D. C.

Lilly Introduces New Corticosteroid

A new oral corticosteroid of marked potency and predictable antiinflammatory effect is being introduced by Eli Lilly and Company under the trademark Haldrone (paramethasone acetate, Lilly). Clinically it has been shown to be well tolerated, the incidence of significant untoward reactions being low.

Duke Pathologist Wins Award

The annual Experimental Pathology award for medical research by a pathologist under 40 years of age was made recently to Dr. Donald B. Hackel, professor of pathology at Duke University, Durham, for investigative work in the fields of cardiac and renal disease.

The citation and a \$1,000 honorarium contributed by Parke, Davis & Company were announced at the annual banquet of the American Society for Experimental Pathology, one of the six member societies of the Federation of American Societies for Experimental Biology.

New Film Series on Physical Diagnosis

A series of 16-mm color and sound motion pictures about various aspects of physical diagnosis is now available for rental or purchase from Wayne State University College of Medicine.

The project was sponsored by CIBA Pharmaceutical Products Inc., Summit, New Jersey, but none of the company's products are mentioned.

All requests for showing or purchase should be directed to the Audio-Visual Utilization Center, Wayne State University, Detroit 2, Michigan.

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pruritus ani et vulvae

stasis dermatitis

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The Month in Washington

The seriousness of the nation's problem of mental illness was emphasized on three fronts recently in the nation's capital.

First, the Joint Commission on Mental Illness and Health reported on a comprehensive five-year study of the over-all problem. Second, another special government advisory committee recommended smaller community-sized mental institutions after a two-year study of facilities for care of the mentally ill. Third, a Senate subcommittee held hearings on the constitutional rights of mental patients.

The Joint Commission recommended sweeping reforms in the treatment of mental illness as well as expanded and improved facilities. It said some gains had been made in the past 10 years but that the need for adequate facilities for humane, healing treating of the mentally ill is still largely unmet.

More than half the patients in state mental hospitals do not receive any treatment, largely because of inadequate facilities, the commission said.

The commission recommended that government spending at all levels—federal, state and local—for public mental patient services be stepped-up in the next decade from the present \$1 billion a year to \$3 billion a year.

Another recommendation was that there be a fully-staffed, full-time mental health clinic for each 50,000 of population.

The commission, which was created in 1955 by a special act of Congress, had 45 members representing every national association and non-government agency concerned with mental health. The American Psychiatric Association and the American Medical Association had the leadership in setting up the commission.

The government advisory committee, composed of 12 state Hill-Burton and mental health authorities, recommended that states concentrate on smaller community or regional facilities "offering a wide spectrum of services."

Dr. Luther L. Terry, Surgeon General of the Public Health Service, urged state governors to use the advisory committee's recommendations as guidelines for improving mental health facilities.

The Senate Constitutional Rights Subcommittee heard from Dr. Winfred Overholser that there is no foundation to charges that many Americans are "railroaded" into mental hospitals. Dr. Overholser is superintendent of St. Elizabeths Hospital, large federal mental institution in Washington, D. C.

Dr. Lauren H. Smith, vice chairman of the A.M.A.'s Council on Mental Health, told the subcommittee that the A.M.A.'s future program in the field will include emphasis on more use of psychiatry in geriatrics, pediatrics and medical education, both at student and postgraduated levels.

Other activities planned for the A.M.A. program include closer coordination of activities of the A.M.A. council and corresponding committees of state medical societies.

* * *

The Food and Drug Administration after the government filed suit against two drug firms for counterfeiting, reported that an extensive investigation showed that there is still relatively little counterfeiting of drugs.

Of 2,700 samples of drugs collected from 900 drugstores in the first three months of this year, only nine were found to be counterfeit.

FDA Commissioner George P. Larrick said he expected the problem of counterfeit drugs to continue because of the lure of easy profits. But he said results of the investigation supported the FDA view that "the facts to date do not warrant disturbing sick people about the quality of medications that they have been taking."

In the counterfeiting suit, General Pharmacal Co., Hoboken, New Jersey, and Lowell Packing Co., Long Island, New York, and eight officials of the two firms were charged with manufacturing counterfeit tranquilizers, diuretics, weight reducers, and other drugs and selling them to drugstores in six states. The Justice Department

charged that the companies put markings on pills making them appear like other trade-marked brands.

* * *

FDR ordered manufacturers, effective May 27, to supply samples of new drugs for testing by the government agency prior to clearance for sale.

In the past, FDR has relied largely on scientific data supplied by the manufacturers themselves in clearing a new drug as being safe for sale. The FDR tested the drugs only on a limited and occasional basis and after they had been put on the market.

* * *

The government is spending \$4.1 billion a year in the health field, a Senate Government Operations Subcommittee reported. In the most detailed report of its kind ever published by a governmental group, the Subcommittee, headed by Sen. Hubert H. Humphrey (D., Minn.), noted that \$1.1 billion of the total care for sick members of the armed forces and their dependents in hospitals. The tab for Civil Service workers' sick leave totals \$315 million a year. About \$650 million a year is spent on medical research, with most of this carried out by the National Institutes of Health and the Veterans Administration.

* * *

The government ordered 250 physicians drafted this year due to the failure of enough interns to sign up for military service. It is the first physicians draft in four years. All of the draftees will be assigned to the Air Force. A department spokesman said the draft call would not prevent individual physicians finishing internship this year from volunteering for Air Force medical duty.

An American male baby born today can look forward to a working lifetime of 42.3 years—11.2 years longer than the working-life expectancy of a male baby born at the start of this century.

—Health Information Foundation

In 1900 the average 20 year old American male could expect to spend only 2.7 years in retirement, Health Information Foundation reports. By 1958, however, retirement-life expectancy for a 20-year-old male had more than doubled, to 6.3 years.

Book Reviews

Atlas of Obstetric Technic. By J. Robert Willson, M.D. 301 pages. Price, \$14.50. St. Louis: The C. V. Mosby Company, 1961.

By emphasizing basic principles of obstetric physiology, pathology and operative technic, Dr. Willson has produced a book which serves as an excellent reference volume for the specialist, resident in training, and the general practitioner. Only those maneuvers necessary to complete delivery at or near term are included.

Beginning with an essential chapter on the professional staff and labor and delivery room facilities, the author clearly and concisely covers normal labor and delivery, induction of labor, third-stage complications, forceps delivery, abnormal presentations and cesarean section, and concludes with an unusually complete discussion of placenta previa. Each subject is introduced with a succinct presentation of the particular problem, and similar commentary accompanies the particularly lucid line and half-tone drawings.

In a book that includes medical as well as surgical techniques, a more extensive discussion of pitocin induction of labor, especially for toxemia of pregnancy, was anticipated. Also, a discussion of forceps delivery seems incomplete without some reference to "trial or failed" forceps. Finally, in these days of radiation awareness, it would seem that more reliance should be placed on the diagnosis of abnormal presentations by vaginal examination, with less emphasis on x-ray confirmation of these findings unless specifically indicated.

This book is particularly useful for anyone practicing obstetrics.

Facts for Childless Couples. By E. C. Hamblen, M.D. 130 pages. Price, \$3.50. Springfield, Illinois: Charles C. Thomas, Publisher, 1960.

Five previous printings and an increasing demand for the present second edition attest to the popularity of this authoritative, yet simple little book. Its lasting accuracy for the past 18 years is apparent in the few changes that have been made in the new edition. Only the revision of a few outmoded concepts and an additional chapter on "New Facts and Fads" were necessary.

The volume continues to be an excellent handbook for the many married couples faced with the perplexing and complicated problem of sterility. It educates these couples in seeking and conducting proper medical care. It can also be of great value to physicians, medical students, nurses, interns, and lay teachers.

In Memoriam

Slade Alva Smith, M.D.

Dr. Slade Alva Smith died at his home in Whiteville, North Carolina, on September 16, 1960. His death will be deeply felt by his patients, friends, and professional colleagues.

He was born on June 4, 1882, in the Welches Creek section of Columbus County, the son of the late Samuel A. and Sarah Jane Brown Smith. He was educated in the schools of that community and at Davidson College. He received his medical education from the Medical College of North Carolina at Davidson, North Carolina, graduating in 1907.

Dr. Smith began the practice of medicine and surgery in Bolton, North Carolina, in 1907 and maintained his practice there for ten years. He then did postgraduate study in New York in the Eye, Ear Nose and Throat Hospital from 1917 to 1919. He then moved to Georgia and practiced his profession there for several years before settling in Wilmington, North Carolina. In 1934 he moved to Whiteville, where he remained doing eye, ear, nose, and throat work until May 1957, when a fall and a fractured hip brought his active practice to a close. He remained a semi-invalid from then until his death on September 16, 1960.

Dr. Smith was an active member of the county, district and state societies, and the American Medical Association. Until his accident he was an active member of the Columbus County Hospital's medical staff. In May of 1957 he was awarded by the North Carolina State Medical Society a 50-year pin and certificate for his half century of service in the medical profession.

He was always deeply interested in public and civic affairs. He was actually Columbus County's first health officer, having been appointed to that position temporarily while practicing

in Bolton. He helped organize the Whiteville Lions Club in 1945, and was its first president. He worked closely with the health department, the welfare department, and the Lions Club in its Sight Conservation program, where he contributed his time and talents without regard to color or creed, or social or financial standing. He was elected and served several times as mayor of Whiteville.

He was a devoted and active member of the First Presbyterian Church of Whiteville, and served for many years as deacon, and then elder, in this church. Be it therefore

Resolved that this community and Columbus County Medical Society has lost a valuable member and each of us a true friend; and that we the members of the Columbus County Medical Society express our deep sorrow and extend sympathy to his family; and that a copy of these resolutions be placed in the permanent files of the Society and a copy be sent to his family and a copy be sent to the **North Carolina Medical Journal**.

A. G. Floyd, M.D.

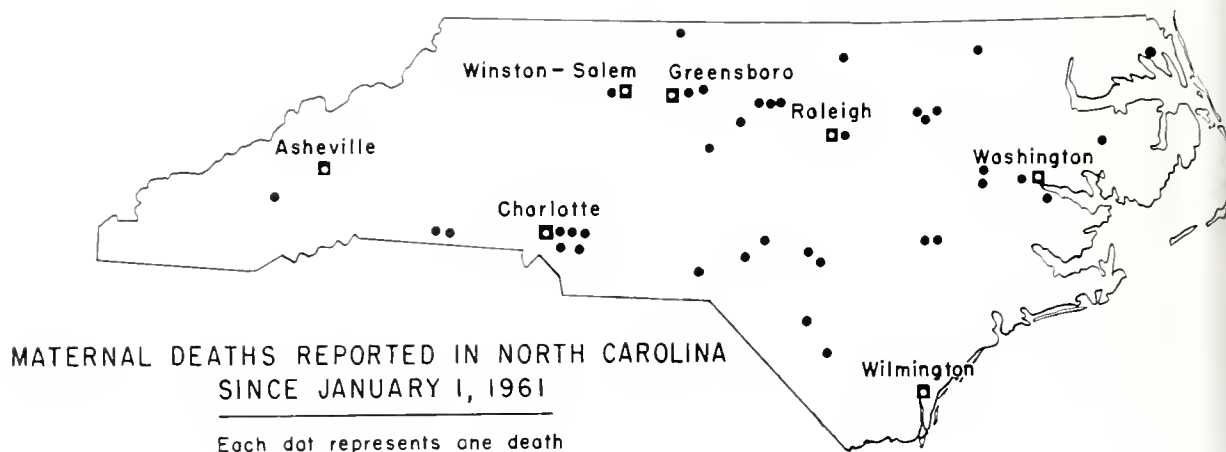
H. G. Walters Jr., M.D.

Hospitals Urged To Baby Patients

A Swiss medical director says hospitals should show more patience toward their patients, even baby them a bit.

"An adult patient is in certain respects rather like a child," writes Dr. Fred Singelisen in *The Modern Hospital*, a professional journal. "He becomes dependent, reduced to the level of a child still dependent upon his mother."

Urging more be done for a patient's mental well-being, the director of Psychiatric Hospital at Wil. St. Gallen, Switzerland, notes that an ill person "is often in greater need of someone to lean on, more exacting, greedier for attention and more self-centered" than a child.



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IN THIS ISSUE:

Chemical Tests for Alcohol Intoxication

William A. Wolff, Ph.D. and James I. Waller, LL.B.

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NORTH CAROLINA MEDICAL JOURNAL

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Chemical Tests for Alcohol Intoxication

Experience with 2,315 Drinking Driver Suspects

WILLIAM A. WOLFF, PH.D.

and

JAMES I. WALLER, LL.B.

WINSTON-SALEM

Among the numerous scientific aids to law enforcement, the chemical test for estimating the degree of intoxication by alcoholic beverages has been widely adopted. This method consists of determining the alcohol content of the blood stream by direct analysis of the blood, or by calculations based on the alcohol content of expired air, saliva, or urine. The first such method to be widely adopted was developed by Widmark in 1922¹. In the United States significant progress in the development of methods for determining blood alcohol was made during the 1930-1940 decade at Yale University and at the Indiana University. Investigators at both institutions worked in close collaboration with their respective state police organizations.

At its 1938 meeting the Medical Society of the State of North Carolina adopted a recommendation for "... the passage of a law requiring (or allowing) any individual charged with drunkenness to have the alcohol content of his blood tested as a measure of intoxication."² The adoption of a chemical test program in North Carolina was urged by an editorial in the NORTH CAROLINA MEDICAL JOURNAL in 1945³. Bills providing for chemical tests have been introduced into several sessions, including those of 1959 and 1961, of the North Carolina Legislature.

By the end of 1960, 32 states had adopted some type of law pertaining to chemical tests for intoxication. Also, Supreme Courts in 42 states, including North Carolina, and the United States Supreme Court have rendered decisions admitting the results of chemical tests as evidence proving the degree of intoxication. The voluminous literature on both the medical and legal aspects of such tests cannot be reviewed here. This paper is a report of experience with chemical tests for intoxication in the third largest city in North Carolina.

Materials and Methods

On July 1, 1951, the Police Department of Winston-Salem, started a chemical test program for drivers charged with O.A.I. (operating an automobile while intoxicated.) This was the first effective and continuing effort to use chemical tests in North Carolina. Blood samples were drawn by hospital personnel at the emergency ward of each hospital in the city. The alcohol analyses were made by Harger's method⁴ in the laboratory of Clinical Chemistry at the Bowman Gray School of Medicine. The test was voluntary in that the arrested driver could refuse it without prejudice to his case. Over a period of nearly nine years a total of 2,315 drivers charged with O.A.I. elected to take the chemical test for intoxication. The blood alcohol levels found in this series of drivers are summarized below, together with some comments on objectives and general aspects of the chemical test program.

¹From the Laboratory of Clinical Chemistry, Departments of Biochemistry and Pathology, Bowman Gray School of Medicine of Wake Forest College, and the Police Department, Winston-Salem, North Carolina.

It is interesting to note that for almost a decade no one in the local jurisdiction has been able to disprove the soundness of this scientific testing program for intoxication. Its acceptance is attested by the following incident which took place in the Municipal Court. During the trial of an individual arrested for driving under the influence, the defendant testified that he had had the customary "two beers." An expert witness took the stand and the judge asked, "In your opinion, based on your examination, how many 12-ounce cans of beer had the defendant consumed?" The witness considered the question and then replied, "Eight cans." Judgment in the case was entered and the judge adjourned court. As the judge left the courtroom he approached the defendant—who was then talking with friends—from the rear. The judge heard the defendant say, "You know, they are just getting too darn smart. I had exactly eight cans of beer."

Objectives

The chemical test program as it was set up in Winston-Salem has three objectives: to protect the innocent, to provide objective scientific evidence, and to facilitate court procedures. First in importance is protection of the innocent. Certain of the chemical tests enable the officer to decide immediately whether the behavior of the arrested driver is due primarily to the effects of alcohol or to some other factor such as injury, a disease, or the effect of drugs. It is important to remember that impairment resembling alcoholic intoxication can arise from insulin shock, heart attacks, epileptic seizures, shock, and injury. There are more than 60 medically recognized conditions which may produce some of the clinical signs and symptoms associated with acute alcoholism. Even the experienced observer may mistake one of these conditions for intoxication by alcohol.

The second objective is confirmation of the officer's observations by impartial scientific evidence. The question to be decided in cases where driving under the influence is charged is whether the defendant's bodily or mental responses at the time

of his arrest are appreciably impaired by the consumption of intoxicating beverages. Without the aid of a scientific testing program, this question must be resolved solely upon the testimony of persons who witnessed the behavior, physical condition, and appearance of the accused at or near the time of his arrest, and the testimony of the accused himself, should he choose to testify.

Observational evidence, to be sure, is desirable and is an integral and important part of the testimony to be given in these cases. The soul-searching question, "Is observational evidence sufficient?" must be answered in the negative. It must be realized that without the benefit of a scientific testing program laymen and police officers must rely on such symptoms as breath odor, incoherent speech, clumsiness, facial discolorations, and abnormal conduct, among others. It is obvious that these symptoms are inadequate—for while they do indicate impairment of the faculties, they may be due to some pathologic condition completely unrelated to the ingestion of alcohol.

The third objective of the chemical test program, the facilitation of court procedures, became apparent after the program had been in operation for several years. It was noted that the chemical test results expedited the handling of O.A.I. cases in the courts, as presentation of evidence required less time and juries reached a verdict more promptly. According to informed opinion, the chemical test program has resulted in considerable savings in court costs.

Preliminary Studies and Preparation

Actual inception of the test program was preceded by nearly a year of intensive study and preparation. Officers were trained to observe details of the appearance and behavior of persons under the influence of alcohol. Tests were made to determine nerve-muscle coordination, reaction time, visual acuity, and impairment of speech. Results of these observations were recorded on the "Alcohol Influence Report Form" prepared by the National Safety Council. Every possible effort was made to accustom the officers to associating the various levels of blood alcohol with the several degrees of

intoxication. After the program was well under way, three officers attended the specialized training course in chemical tests at the Traffic Institute of Northwestern University.

A chemist was engaged to make a special study of chemical methods for determining alcohol in blood. A comparison was made between the blood alcohol level determined directly and as determined by the Intoximeter breath method in a series of 50 subjects.* In preparation for court testimony, the expert witness for the state made an experimental study of the relationship between the amount of alcohol consumed and the resulting blood level. The effect of alcohol on reaction time and nerve-muscle coordination was studied in a second series of experiments on subjects who drank regularly. Using equipment provided by the State Highway Patrol, the effect of alcohol on the impairment of vision in both "light" and "heavy" drinkers was determined. On the basis of this first-hand experience, together with knowledge of similar results in the published literature, the state's expert witness was prepared to testify in court.

From the very inception of the program the judges and solicitors of the several courts in Winston-Salem were advised of the research undertaken and its results. As the program progressed, constant liaison was maintained with these court officials in order that they might be kept abreast of all developments. Also, the judges and solicitors were furnished the numerous decisions of appellate courts regarding the admissibility of evidence as a consequence of chemical tests for intoxication. Complete harmony and understanding has existed at all times since the commencement of the program.

A systematic program of publicity was undertaken to acquaint the general public with the new program for tests on drinking drivers. All media of public information, including the press, radio and television, fully cooperated in disseminating information. Also, principals in the program appeared before civic clubs and other organizations

in the community and demonstrated the equipment and technical methods before large numbers of interested citizens.

Handling the Sample

The chemist personally prepared the container for blood (20 ml. glass bottles with tightly fitting rubber stoppers), added the oxalate and fluoride, an anticoagulant and preservative, and sealed the bottles in small paper envelopes. These were held in the Police Department until needed at the hospital. Sterile syringes and needles, steam-autoclaved and dried, were prepared at the hospital. The site for the venipuncture, usually the area superior to the median cephalic vein, was sponged with aqueous Zephiran chloride and the blood sample was drawn by a physician, registered nurse, or medical technologist. The blood sample was divided between two oxalated bottles still in the possession of the officer, who immediately sealed and labeled them. They were then taken to the Police Department and locked in a box built and operated like a night deposit box at the bank. This box was kept in the refrigerator until the chemist opened it, removed the samples, took them to the laboratory, and started the analyses. The sample bottles were kept in locked boxes stored in a refrigerator until the court disposed of the case.

The above procedure permits the chain of possession to be known from the time the blood is drawn in the hospital until the sample is presented in court. It also permits the officer who had the blood drawn to identify the sample in court and testify that it was drawn from a given defendant at the time stated. The importance of maintaining an unbroken chain of possession and adequate identification of the sample cannot be overemphasized.

Observations on Drinking Drivers

Blood alcohol levels: Blood alcohol levels, expressed as grams per 100 ml., found in 2,315 drinking drivers are shown in table 1. To conserve space, the figures are grouped in spans of 0.05 per cent except for 0.15 per cent, the "cut-off point" accepted by many authorities in the United States. Only 35

*Recently a comparison was made between the blood alcohol levels determined directly and the results obtained by the Breathalyzer method in 56 subjects.

Table 1

**Blood Alcohol Levels Obtained
In 2,315 Drinking
Driver Suspects**

Per Cent (Gm. per 100 ml.)	No. Cases
0.0-0.05	13
0.06-0.10	22
0.11-0.14	125
0.15-	32
0.16-0.20	642
0.21-0.25	812
0.26-0.30	477
0.31-0.35	149
0.36-0.40	38
0.41 plus	5

drivers showed levels of blood alcohol below 0.10 per cent. This group included several persons under the influence of drugs, one victim of polio with permanent damage to the nervous system, and several others with driving ability impaired by some disease process. There were 125 drivers in the 0.11-0.14 per cent range, and 35 with exactly 0.15 per cent. The great majority of the drivers, 1,931 or 83.4 per cent of the total, showed levels in the range of 0.15-0.30 per cent. Only 192, 8.3 per cent of the total, showed levels above 0.30 per cent. Only 5 drivers had levels of 0.41 per cent or higher.

Age distribution: The officer making the arrest reported the age of 2,230 drinking drivers in this series. The age distribution by decades is shown in table 2. The drinking drivers arrested ranged in age from 16, the minimum legal age for obtaining a driver's license in North Carolina, to 78. While 1 out of 6 drivers was in the youngest age group, 16 to 25, nearly two thirds of the total, were between the ages of 26 and 45. Another 13 per cent were between 46 and 55. At least 31 drivers were in their 60's and 4 were 70 and older.

The woman driver: In this series of drivers arrested and charged with O.A.I. were 94 women, approximately 4 per cent of the total. Information on the women was carefully reviewed with the object of finding any differences between the sexes. Data on both groups are almost identical. The levels of blood alcohol were virtually the same in both groups. For example, 28.7 per cent of

Table 2

**Age Distribution of 2,230
Drinking Driver Suspects**

Ages (Years)	No.	Per Cent
16-25	372	16.7
26-35	793	35.6
36-45	674	30.2
46-55	300	13.4
56 and over	91	4.1

the women were in the 0.16-0.20 range as compared with 27.6 per cent of the entire group. Likewise, 84.0 per cent of the women and 83.4 per cent of the entire group were in the 0.16-0.30 range. About the only difference between the two groups is the fact that a great majority of the women gave their age as "under 35." One woman, however, reported her age as 57.

Protection of the Innocent

The most dramatic feature of the chemical test program is protection of the innocent person who is arrested and charged with O.A.I. because "he acted like a drunk." In these cases the chemical test indicated that alcohol was not the explanation for the manner of driving, although it and other behavior suggested intoxication. Our files include a number of such cases which will be reported in detail elsewhere. The following excerpts are taken from cases selected as examples of three situations frequently encountered by law enforcement officers. These excerpts give added weight and impetus to the proposition that observational evidence alone is not adequate in O.A.I. cases.

Cerebral accident: An elderly Negro male was driving East on Fifth Street when he started weaving from curb to curb, sideswiped a parked car, drove another block and sideswiped a second parked car, then swerved left and drove under the wheels of an oncoming trailer-tractor rig. On being removed from the wreckage he was muttering incoherently and was unable to stand or execute voluntary motions as directed. Five persons who saw his driving and the accident agreed to appear in court and testify that he was "driving drunk." A blood alcohol test done "stat" revealed no alcohol present. The medical examination revealed hemiplegia with right sided paralysis. The family was told that the man had had a "stroke." No arrest was made and no charges were preferred.

Brain injury in an accident: A middle aged pharmacist returning from a business conference crashed into the rear of a parked truck. The officer investigating the wreck noted a marked odor of alcoholic beverage on the driver's breath; an inability to walk and turn; slow, uncertain motions; slurred speech, and mental confusion. The driver admitted having had one "high ball." At the emergency ward of the hospital an intern made a cursory examination and reported to the officer, "You do not need an alcohol test to show that this man is under the influence." Expecting a high alcohol level, the officer made a test with the Intoximeter. The result indicated little alcohol, probably less than 0.05 per cent, in the blood stream. The test was repeated with a second Intoximeter unit which gave the same result. On continuing the medical examination, the intern found that a small piece of metal had been driven into the frontal area of the skull in a direction almost parallel with the surface. A neurosurgeon was called to give immediate attention. No arrest was made.

Effect of drug: A barber, a white male, aged 26, was arrested and charged with O.A.I. His behavior was typical for a person under the influence of alcohol—namely, poor coordination, slurred speech, mental confusion, and marked impairment of driving ability. The officer did not note the odor of alcoholic beverage, and the driver insisted that he "hadn't touched a drop in a year." The blood alcohol determination was negative. On being consulted, the driver's physician reported that he had prescribed a tranquilizer, advising the patient not to drive after taking the drug. The patient disobeyed the physician's instructions. In court the solicitor did not prosecute the O.A.I. charge.

Discussion

A chemical test program for alcoholic intoxication, like any other medicolegal procedure, must meet two sets of requirements, the scientific and the legal. All details of handling the equipment and blood samples must meet the most exacting scientific standards. Analytical methods must give accurate, dependable results. All possibilities of errors of any kind must be eliminated or reduced to insignificant levels. The sample must be handled in such a way that loss, deterioration or tampering is prevented, and the chain of possession must be proved and remain unbroken. The officer must be able to testify in court as to the identify of the sample, its source, and the circumstances under which it was drawn. The chemist must be able to testify as to the

accuracy of results, and establish, to the satisfaction of the court, his competence as an analyst.

In addition to producing a person competent to make analyses, the state, in the absence of definitive legislation, must tender an expert witness who can discuss the physiologic significance of blood alcohol levels, especially their relation to nerve-muscle coordination, reaction time, and impairment of vision. This expert also must be able to state the effects of alcohol on both physical and mental functions, and the relative degree to which driving ability is impaired. Still further, he must know how alcohol is absorbed in the body, distributed to the tissues, metabolized, or excreted.

Using blood alcohol levels as confirmatory evidence is only a part of the trend toward objective scientific methods in law enforcement work. Photography and fingerprints have been an integral part of crime investigation for many years. The science of ballistics and many other laboratory aids are employed daily. Radar devices are used to determine speed on the highways and streets. A few progressive communities have adopted the medical examiner system. Modern chemical test methods permit a scientific determination of an individual's condition of sobriety.

Two very practical purposes are served by dividing the blood sample between two bottles. The second portion of the sample is available for analysis in the event that the first portion is lost through breakage, a defective seal, contamination, or accident. Furthermore, the second bottle, with its seal intact, may be forwarded to another laboratory for a confirmatory analysis. This has been done in several cases at the behest of the defense attorney. In these instances identical results were obtained in both laboratories.

By making the test optional for the arrested driver and taking the blood sample only with his permission two troublesome problems are avoided. First, the constitutional issue of forcing the driver to submit to a test procedure is eliminated. Second, the doctor or other person drawing the

blood is protected against the possibility of a damage suit alleging forcible assault.

Summary

Experience in setting up a chemical test program for intoxication by alcohol is reviewed, with emphasis on the procedures necessary to meet both legal and scientific requirements. Blood alcohol levels found in 2,315 drinking driver suspects are reported.

Experience with the chemical test program for alcoholic intoxication has amply demonstrated its value in protecting the innocent, aiding law enforcement, and facilitating court procedures. These methods give the enforcement agencies one more effective tool for obtaining objective, scientific, and impartial evidence to be presented in the courts. Such evidence goes a long way toward eliminating guesswork and subjective

opinions from court hearings. On the other hand, the test program gives the motoring public added protection against the hazard of drunken drivers on the road.

Acknowledgment

The authors are indebted to a large number of law enforcement officers, to numerous hospital personnel, and to several city officials who have worked conscientiously and have generously given time and advice in an effort to make a success of the chemical test program for intoxication.

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The Early Diagnosis of Congenital Glaucoma

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DURHAM

The responsibility for the early diagnosis of congenital glaucoma in infants rests principally with the pediatrician, the family physician, and the obstetrician. They are usually the first to note the signs of congenital glaucoma at birth and are frequently the first consulted in the subtle cases that begin after birth. As a result, any progress made in the early detection and subsequent treatment of congenital glaucoma is dependent on the vigilance of these physicians.

Since 1942, when Barkan applied the goniotomy operation to the treatment of glaucoma, the prognosis and outlook for patients with this disorder has improved remarkably¹. The earlier in the course of the disease that treatment is instituted, the greater is the chance of controlling intraocular pressure and subsequently halting the destructive process.

Because of advances in treatment and the importance of starting this treatment before

the eye is damaged by glaucoma, it is considered appropriate to reconsider some salient points in the diagnosis and treatment of congenital glaucoma and to illustrate them with selected case histories.

Congenital glaucoma is a rare disease occurring in 0.03 per cent to 0.079 per cent of an ophthalmologic clinic population². In spite of its rarity, its inexorable course in the past has resulted in blindness in from 2.4 to 13.5 per cent of children in institutes for the blind.

Congenital glaucoma is an increase in the intraocular pressure, usually manifest before the age of 3 years and not caused by an obvious congenital lesion. It may be unilateral or bilateral, and affects both Negro and white children almost equally. Scheie has reported that 31 per cent of cases were diagnosed at birth and 69 per cent after birth³.

Symptoms and Signs

The earliest symptoms of the disease are

From the McPherson Hospital, Durham, North Carolina.



Fig. 1. The left eye is buphthalmic from congenital glaucoma; the corneal diameter was 14 mm. The right eye was normal.

photophobia, lacrimation, or blepharospasm. Children under 2 or 3 years of age in whom these symptoms persist should be investigated for the possibility of congenital glaucoma. The signs are a cloudy, hazy, or enlarged cornea (figure 1.). The parents may state that the "eyes are white," or that the "child has a cataract," or they may have noted that the child "had large blue eyes that began to get too large."

Unfortunately none of our patients with congenital glaucoma were seen until the gross signs of the disease were present. Of 19 patients, all had mild to severe cloudiness of the cornea when first seen, and 16 had obvious corneal enlargement. Photophobia was the most commonly associated symptom, being reported in 10 of the 19 patients. The cloudy cornea has various degrees of opacity, the earliest stage being a bedewing or haze, which clears immediately at operation, or spontaneously as the pressure falls in the affected eye. The hazy cornea becomes opaque when there are breaks in Descemet's membrane. These breaks produce a serpentine lesion in the deep corneal tissue. In later stages the cornea appears grossly white, an indication of almost irreversible scarring.

Diagnosis

The diagnosis depends ultimately upon the measurement of the intraocular pressure. This must be done in stage 3, plane 3 of ether anesthesia. Without anesthesia, or in light planes of anesthesia, there are

false high readings which can be misleading. The intraocular pressure is measured with a Schiotz tonometer, and readings above 25 mm. of mercury are suggestive of the disease, while readings above 30 mm. are virtually diagnostic.

The measurement of the corneal diameter is also of paramount importance. In early infancy the normal corneal diameter is considered to be 11 mm. or less. Any diameter measuring above 12 mm. is strongly suggestive of congenital glaucoma. The corneal diameter is also an excellent indication of the efficacy of treatment and aids further in the diagnosis. An increase in the diameter in a doubtful case indicates the presence of congenital glaucoma and in a proven case indicates failure of control.

The fundi often cannot be visualized because of corneal edema, but when observed are usually normal. Because of the elasticity of the fibrous coat of the eye, increased intraocular pressure causes the eye to become buphthalmic before inflicting any visible damage on the optic nerve.

It must be realized that the final diagnosis is based on the sum total of the physical findings, especially in borderline cases. Occasionally, a child with only a symptom of photophobia and a high normal intraocular pressure must be observed over a period of time before the diagnosis can be confirmed.

Treatment

The treatment of congenital glaucoma is surgical. Haas has reported that in a series of 329 eyes with congenital glaucoma, none were controlled with miotics⁴. He also believes that the postponement of surgical treatment of congenital glaucoma because of medical therapy only deprives the patients of better results which might be anticipated from early surgery⁴. Before goniotomy became the procedure of choice, the percentage of control with external filtering operations was 40 to 50 per cent². The use of goniotomy or goniotomy has increased this percentage to from 77 to 85 per cent in large series^{3,4}. The technique of goniotomy or goniotomy has been described in detail⁵.

Briefly, the procedure is performed under ether anesthesia: a stiletto type blade is introduced at the limbus, passed across the anterior chamber to the chamber angle opposite the incision, and the angle is swept for approximately 45 degrees of the circumference, apparently removing the blockage to the aqueous outflow channels of the eye. A goniopuncture is a puncture made with this stiletto blade that produces a small drainage channel between the anterior chamber and the subconjunctival space, thereby allowing escape of aqueous (figure 2).

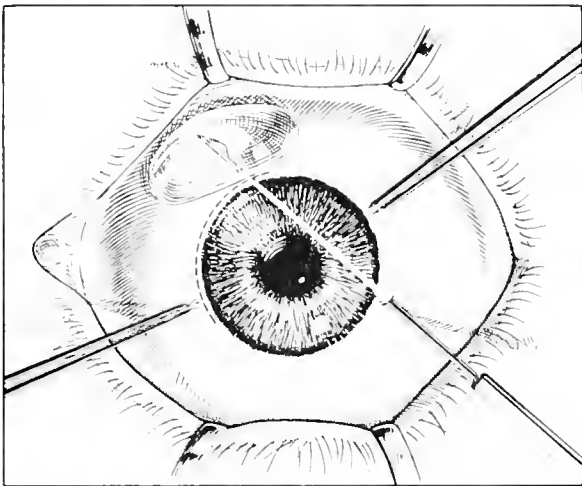


Fig. 2. In performing a goniopuncture, the goniotomy knife is passed across the anterior chamber into a bleb of conjunctiva. The broken line indicates the previously performed goniotomy. (Reprinted with permission of the Southern Medical Journal)

Case Reports

Case 1

A 3 month old Negro female was admitted for treatment of "cataracts in both eyes." Her eyes had been "white" since birth. The past history and family history were noncontributory. A general physical examination was normal except for enlarged, opaque corneas. Laboratory studies revealed a hypochromic anemia, with 7.9 Gm. of hemoglobin. A sickle-cell preparation was negative, as were other laboratory studies. Because of the low hemoglobin, repeated transfusions of 25 cc. of whole blood were given until the hemoglobin reached a level that would permit safe general anesthesia.

During stage 3, plane 3 of ether anesthesia, the intraocular pressure was elevated to 37 mm. of mercury in the right eye and 47 mm. of mercury in the left eye. Corneal diameters measured 13 mm. in both eyes. Goniotomy and



Fig. 3. (Case 1). The right eye shows corneal scarring with moderate enlargement. The left eye had a similar appearance.

goniopuncture were performed in the inferior nasal quadrant of both eyes. Two days later repeat goniotomy and goniopunctures were performed in the superior nasal quadrants. After an uneventful postoperative course, the child was discharged on the fifth postoperative day.

Re-examination six weeks later under general anesthesia revealed a normal tension of 20 mm. of mercury in the right eye, with no increase in the corneal diameter; however, the left eye had a tension of 38 mm. of mercury but no increase in the corneal diameter. Thus a goniotomy was performed in the superior temporal quadrant of the left eye.

Examination two months after her original admission showed a normal tension of 18 mm. of mercury in both eyes, and no increase in the corneal diameters (figure 3).

Comment: Obviously this child suffered from parental neglect. Her original hypochromic anemia was probably nutritional in origin. The delay in seeking medical care was unfortunate and prejudiced the prognosis unfavorably. This case also illustrates the fact that, although identical procedures are performed on the same patient with no change in technique, the results are unpredictable at time of operation. As in this case, one eye has been controlled for three months, while the other eye has been under control only six weeks. Examination four to eight weeks after the original operation is necessary to determine the success of the procedure.

Case 2

A 5 month old white male was referred for treatment at McPherson Hospital with a diagnosis of congenital glaucoma. One month prior to admission, the child had lacrimation and



Fig. 4 (Case 2). The right eye shows moderate corneal enlargement, but the cornea is clear after being under control for one year. The left eye has a similar appearance.

marked photophobia and was treated with various salves without benefit. The eye began to get noticeably larger and hazy approximately two weeks before admission. Past history and family history were noncontributory. Examination revealed enlarged corneas that were slightly hazy. The remainder of the physical and laboratory examinations were normal.

Under ether anesthesia, at plane 3, stage 3, the intraocular tension was elevated to 46.5 mm. of mercury in both eyes. The corneal diameter was 13.5 mm. Consequently, goniotomy and goniotomies were performed bilaterally.

In the following three months three more goniotomies were performed on the right eye, and two more on the left eye. The corneal diameters increased 0.5 mm. in that period of time. Since the third month, however, the intraocular tension has been normal at every

examination up to the present—a period of one year. The corneal diameters have remained stationary also. The patient can pick up small coins, plays well with other children, and his overall visual function appears to be relatively normal for his age. (figure 4)

Comment: An early diagnosis in this case gave a better prognosis than the previous one. Multiple surgical procedures are frequently necessary before permanent control of the intraocular pressure can be reasonably assured. This case also illustrates the insidious onset that may be present with this disease.

Summary

1. The symptoms, signs and treatment of congenital glaucoma are reviewed, and two case histories are presented.
2. Early diagnosis, accompanied by newer methods of treatment, offers a better prognosis in this rare though potentially disabling disease.

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... Good physical examination ... requires more than the usual foggy remembrance of anatomy that is shared by so many of our graduates today. At the end of a good history and a competent physical examination, often we have gone the distance in the diagnostic study of a patient, laboratory examination being only confirmatory or even unnecessary. When further study is required, we are in the enviable position of being able to call upon our technologic and other aids with precision and without waste of time and money.—Lewis, H. P.: Reflections from our Mirror, *Ann. Int. Med.* 53: 1206 (Dec.) 1960.

Surgical Treatment of Glaucoma

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All ophthalmologists admit that the results of operations for glaucoma are far from satisfactory even in the hands of the most skilled ophthalmic surgeon. Yet when medical therapy has failed, surgery may be the only alternative to blindness. Thus it is imperative that the most appropriate procedure be selected for each type of glaucoma.

The diagnosis of acute glaucoma is not difficult; however, cavernous atrophy of the optic nerve and chiasmal lesions have been mistakenly operated on for chronic glaucoma. For this reason, prior to surgery all patients should have a complete medical and meticulous ophthalmologic examination.

Naturally, glaucoma entails a certain amount of psychologic trauma. For this reason, it is most important to establish complete rapport with the patient undergoing surgical treatment. The expected visual results should be frankly discussed, unless there are extenuating circumstances. The patient who has wide-angle glaucoma should be told that improvement of vision is not likely, but that surgery is necessary to prevent further loss of vision. Consultation with another ophthalmologist should be advised if operation is refused. This not only divides the responsibility, but is more likely to impress the patient with the seriousness of his disease.

Glaucoma in the aged and in patients whose life expectancy is being shortened by some serious illness should be treated medically, if possible, even though there is progressive loss of visual fields.

It is not the purpose of this paper to describe the techniques of the various operations for glaucoma; however, some comment will be made concerning the merits of these procedures as well as some of the major complications that may occur. It is

impossible to classify arbitrarily all cases of glaucoma requiring surgery, but for convenience of discussion they will be categorized as follows: wide-angle glaucoma, angle-closure glaucoma, congenital glaucoma, and secondary glaucoma.

Anesthesia

The local anesthetic of choice is 2 per cent Xylocaine Hydrochloride with epinephrine. Hyaluronidase is added when further lowering of the intraocular tension is desired. One-half per cent topical Pontocaine Hydrochloride is first instilled into the eye. A modified Van Lint or O'Brien lid block is then done. This is followed by retrobulbar injection. Swan¹ believes that retrobulbar injections are unnecessary for operations in chronic glaucoma and prefers topical anesthesia combined with anterior subcapsular injections. The agent is injected 5 mm. back from the limbus and massaged forward.

Adults are given intravenous Pentothal when general anesthesia is indicated. Infants are given ether. If diathermy or cautery is used in either case, the anesthetic should be temporarily discontinued and a wet towel used to cover the ether mask to prevent possible explosion. More recently, fluothane, a non-explosive inhalation anesthetic, has been used with excellent results.

Chronic Simple Wide-Angle Glaucoma

There is general agreement that medical treatment is preferred for chronic simple wide-angle glaucoma. Surgery is indicated in this type of glaucoma only when medical management fails. Since the etiology is poorly understood, ophthalmologists differ as to the indications for surgery and the choice of operation to be performed.

Surgery is indicated in chronic simple wide-angle glaucoma when there is persistent elevation of the intraocular pressure and progressive loss of visual field with

¹From McPherson Hospital.

Read before the Section on Ophthalmology and Otolaryngology, Medical Society of the State of North Carolina, Raleigh, May 11, 1960.

medical therapy. Scheie² states that a constant pressure of 40 mm. of mercury or higher is an indication for surgery, since an eye cannot carry this tension for long periods without undergoing deterioration. The ophthalmologist is more often confronted with patients having slight to moderate elevation of tension with varying degrees of glaucomatous cupping and progressive loss of visual field. Surgery should be performed as soon as the indications are clearly established, if one hopes to preserve vision. The prognosis is best in those patients who show minimal changes in the optic disc, with little or no field loss.

The obstruction to aqueous outflow in wide-angle glaucoma is in Schlemm's canal or its outlets. Iridectomy cannot be expected to be effective. A new outlet for the aqueous may be created by means of iridencleisis, Lagrange sclerectomy, or Elliott trephine. If the intraocular tension is not sufficiently reduced by one of these operations, cyclodialysis or cyclodiathermy may be done as a secondary procedure.

Recently Scheie³ has described a new filtering operation. This is accomplished by utilizing a cautery to produce shrinkage of the sclera when the incision is made into the anterior chamber. A permanent fistula results. This operation can be used in either wide-angle or angle-closure glaucoma, but is most applicable to neglected cases of the latter. Preliminary results of this procedure are encouraging.

I personally prefer either iridencleisis or anterior sclerectomy with peripheral iridectomy to trephine. Technically, these procedures are easier to do, and there is less likelihood that the lens will be injured or the fistula blocked by the lens or iris. Both iridencleisis and anterior sclerectomy usually produce larger and thicker filtering blebs than does the trephine, and there is less chance of late infection of the bleb.

The main advantage of anterior sclerectomy with peripheral iridectomy over iridencleisis is that there is less visual distortion. This is extremely important to a wage earner. Iridencleisis may be followed by considerably more postoperative reaction than anterior sclerectomy; however, this is

usually controlled by the local and systemic use of steroids.

There is considerable difference of opinion concerning one-pillar versus two-pillar inclusion in iridencleisis. Both iris pillars should be included if the intraocular pressure is markedly elevated.

Other procedures

Some ophthalmologists prefer cyclodialysis as a primary procedure in chronic wide-angle glaucoma. Others have not been impressed with it as a first operation in phakic glaucoma; however, it is a valuable secondary procedure after a filtering operation. More recently, some operators have modified the original technique by making the scleral incision closer to the limbus. It is felt that this lessens the chance of hemorrhage during and after the performance of the procedure.

Cyclodiathermy has become more widely accepted as a secondary operation in wide-angle glaucoma. It may be used as a primary operation in the Negro. The different techniques for performing cyclodiathermy have become more refined through experience. In the past, this procedure was reserved only for eyes which were already beyond salvage by any other operation. When the operation was first performed, too much diathermy was used, often resulting in an early phthisis bulbi. The intraocular tension may become markedly elevated immediately following some cyclodiathermy procedures, necessitating posterior sclerotomy. I prefer the technique described by Stocker⁵.

Enucleation is advised if chronic wide-angle glaucoma has progressed to absolute glaucoma, and if the eye is painful. Surgery is deferred if the eye is comfortable and the "fundus" can be visualized to rule out intracocular tumor. Cyclodiathermy may be done if enucleation is refused. Alcohol can be injected when surgery of any kind is refused.

One occasionally meets the problem of surgical cataract in wide-angle glaucoma. The cataract may be extracted first if the glaucoma is controlled medically; otherwise, some sort of filtering procedure is in-

licated as the initial operation. After the tension has been normalized the cataract may be removed. I prefer to do this through a corneal incision in front of the filtering bleb.

Hughes⁶ has described a technique of combining cataract extraction with anterior sclerectomy and iris inclusion. He states that this procedure may be used for any type of primary glaucoma with cataract. Wenaas and Stertzbach⁷ have combined cataract extraction with iris inclusion only. The results reported with these combined procedures are impressive.

Complications

Hyphema is one of the more frequent complications of glaucoma surgery. It may occur at operation or be delayed. Nothing need be done if the hemorrhage is slight. Severe hemorrhage at operation may be partially controlled by allowing the blood to clot and then removing the clot from the anterior chamber. Injection of air may help. In a delayed massive hyphema, Diamox should be used to prevent secondary rise in tension. Paracentesis or evacuation of the clot may be necessary.

One of the commoner postoperative complications is flat anterior chamber. This condition may be associated with choroidal detachment. It can be reduced by injection of air and by meticulous closure of Tenon's capsule and the conjunctiva at the time of operation. Air may be injected through a cyclodialysis opening if the flat anterior chamber has not reformed by the fourth or fifth postoperative day. Many ophthalmologists will do nothing as long as the eye is soft. One should suspect malignant glaucoma if the pressure in the eye suddenly rises. If this pressure cannot be corrected by air injection and the use of carbonic anhydrase inhibitors, the lens should be removed. It is generally agreed that Diamox alone does not re-establish the anterior chamber.

Hypotony may follow glaucoma surgery. This is more often seen following the Elliott trephine. It is thought that hypotony hastens the development of cataract. It may be

corrected by making a new conjunctival flap if it is due to a leaking filtering bleb or one that is filtering too rapidly. Friedenwald¹ has suggested cauterizing the bleb with 5 per cent silver nitrate. A late postoperative complication following filtering operations for glaucoma is cataract formation. This seems most often following iridencleisis.

One common cause of failure in filtering operations is loss of the bleb through the formation of scar tissue. It has been my experience that this complication is more frequently observed in the Negro race.

An infrequent later complication is infection of the filtering bleb. This requires extensive antibiotic therapy.

Angle-Closure Glaucoma

The accepted treatment for angle-closure glaucoma is surgical. A sound therapeutic basis has been worked out for the treatment of this condition, in contrast to wide-angle glaucoma in which the mechanism is not completely known. Increased intraocular tension in angle-closure glaucoma is caused by obstruction of the chamber angle by the root of the iris. Iridectomy will establish the free passage of aqueous from the posterior chamber to the chamber angle, as the obstruction is within the eye.

The patient with acute angle-closure glaucoma should be prepared medically for surgery. The duration of the glaucoma and response to medical therapy are important factors in determining which procedure should be performed. Gonioscopy and tonography are usually unsatisfactory in the acute congestive phase, but will help determine whether to perform peripheral iridectomy or a filtering operation when medical therapy has produced a normal tension. Peripheral iridectomy should be selected if medical therapy results in prompt control of the glaucoma and the aqueous outflow is normalized. A filtering procedure, preferably iridencleisis, should be done when the response to medical therapy is slow or poor and the aqueous outflow is diminished. A filtering operation is usually necessary when acute glaucoma has been present for 24 hours or more.

Repeated bouts of glaucoma often lead to the development of anterior peripheral synechiae, with some embarrassment to the chamber angle. The surgical management of chronic angle-closure glaucoma will depend entirely on the gonioscopic and tonographic findings. A peripheral iridectomy may be adequate in the early stages; however, in most instances, a filtering operation will be necessary.

It is safer and technically easier to perform a peripheral iridectomy with an *ab externo* incision. This incision may be made either at the 12, 10 or 2 o'clock position and the iridectomy performed at the corresponding site. It is important that air be injected into the anterior chamber following the procedure or through a previously prepared incision in the inferior cornea as described by Chandler⁸. The incision should then be tightly closed with either a pre-placed or post-placed corneoscleral suture in order to reestablish the anterior chamber as soon as possible. Following the peripheral iridectomy, the iris should be inspected carefully to be sure that its excision has been complete.

The advantage of performing the peripheral iridectomy nasally or temporally instead of at the 12 o'clock position is that a filtering procedure may be performed on the undisturbed opposite side later should the need arise. The disadvantage of doing surgery at the ten and two o'clock sites is that occasionally the upper lid will not completely cover the peripheral iridectomy. This usually results in increased photophobia and some troublesome monocular diplopia.

The preferred filtering operation in angle closure glaucoma is iridencleisis. The post-operative visual results from this operation cannot begin to compare with those of peripheral iridectomy. There is also the late complication of cataract formation. It would seem best, therefore, to try peripheral iridectomy first, in borderline cases where there is a possibility that this operation may work.

Scheie's³ procedure is theoretically supposed to work well in chronic angle-closure glaucoma.

Tonography will help determine whether iridectomy or cataract extraction should be done as an initial procedure if angle closure glaucoma is accompanied by cataract. According to Sugar⁹, the management of surgical cataract in acute primary glaucoma depends on whether the eye is in the congestive or non-congestive phase. The cataract should be extracted first if the tension can be controlled medically. The glaucoma operation should be carried out first when the tension remains elevated and the eye congested.

Much has been written concerning the fellow eye in angle-closure glaucoma. Studies by Winter¹⁰ have shown that there is a strong possibility that the second eye will become involved within five years after the condition develops in the first eye.

Opinions differ as to the management of the second eye. Chandler¹¹ believes that a prophylactic peripheral iridectomy should be performed, even though there are no symptoms of glaucoma and the mydriasis test is negative. Scheie¹² believes that the second eye should be treated conservatively if this test is negative. The results of glaucoma studies, the age and cooperation of the patient, and other factors are important in making this decision.

Congenital Glaucoma

The treatment of congenital glaucoma is early operation before irreparable damage to the eye results. In this type of glaucoma, there is either an obstruction to the trabeculae by embryonic tissue or some obstruction to aqueous outflow in the trabecular area. This is due to some congenital maldevelopment.

Barkan¹³ revolutionized the treatment of congenital glaucoma by reviving and improving the technique of goniotomy originally described by De Vincentiis. More recently Scheie¹⁴ developed the operation of goniotomy. These two procedures either alone or combined are the operations of choice in congenital glaucoma. According to Scheie¹⁵, the best results are obtained when goniotomy is done on completion of the goniotomy incision. If these procedures are not successful initially, they may be re-

peated; however, the chances of success rapidly diminish with each operation.

Cyclodiathermy may be tried when goniotomy and goniopuncture have not succeeded in normalizing the intraocular pressure. Filtering procedures are notoriously unsuccessful in congenital glaucoma.

If photophobia and tearing persist after operation and the tension is 30 mm. of mercury or more under general anesthesia, the glaucoma is not under control and further surgery is required. According to Maumenee¹⁶, if goniotomy is successful for one year, it usually continues to be successful.

The most frequent complication of surgery for congenital glaucoma is hyphema at the time of operation. Fortunately, it is rarely severe. Other possible complications are iridodialysis and traumatic cataract.

Secondary Glaucoma

Secondary glaucoma is due to an obvious mechanical obstruction of the chamber angle or trabeculum. This may result from injury, operation, infection, degeneration or tumor. It is impossible to give any specific rules for the surgical treatment of secondary glaucoma. Chandler¹⁸ has offered a good general rule: "The surgical treatment of secondary glaucoma is to use conservatism consistent with maintaining the vision of the eye. Never employ a big operation if a minor one will tide things over." The surgical treatment of the more important causes of secondary glaucoma will be discussed.

The use of steroids and carbonic anhydrase inhibitors has made the treatment of iridocyclitis or anterior uveitis less difficult; however, some patients have a persistent elevation of intraocular tension which requires surgery. A single paracentesis may be all that is necessary, especially in an acute process. The two most effective procedures are iridectomy and cyclodialysis. If iris bombe is present, a transfixion operation may be done.

Severe hyphema with secondary glaucoma can be a very difficult problem to treat. Repeated paracentesis may be necessary when the increased intraocular tension cannot be controlled medically with

carbonic anhydrase inhibitors. This is preferred to keratome incision with irrigation of the anterior chamber.

Secondary glaucoma may be associated with cataract when the lens suddenly becomes intumescent. Glaucoma may also occur when the lens capsule ruptures or leaks spontaneously. The treatment for this condition is medical control of the tension followed by cataract extraction.

Glaucoma following cataract extraction deserves special mention. This complication can be prevented to a degree by careful attention to closure of the wound and correction of flat anterior chamber when it occurs. Cyclodialysis is the operation of choice if the glaucoma cannot be controlled medically. This procedure may be repeated. Some ophthalmologists prefer cyclodiathermy for glaucoma following cataract extraction. Glaucoma may occur following discissions of lens material after an extracapsular cataract extraction. Cyclodialysis is the usual treatment if the tension cannot be controlled medically. A subluxated or completely dislocated lens may give rise to secondary glaucoma. The lens should be removed as promptly as possible. In posterior dislocations this complication can be hazardous. Removal of the lens does not always normalize the tension, and some type of glaucoma procedure may be necessary. Cyclodialysis or cyclodiathermy may work in such cases.

Increased intraocular tension due to intraocular tumor is treated by enucleation, including an adequate length of the optic nerve. An intraocular tumor should be suspected when the fundus cannot be visualized in a glaucomatous eye.

Glaucoma capsulare or glaucoma due to exfoliation of the lens capsule is seen occasionally. Surgery becomes necessary when medical treatment fails. A cataract, if present, should be removed if the tension can be controlled; otherwise cyclodialysis or some filtering operation should be performed first.

Rarely, glaucoma follows cataract extraction or penetrating corneal wound because of epithelial downgrowth. This has been treated successfully by removal with iridec-

tomy. Maumenee¹⁷ has combined iridectomy with curettage of the involved cornea.

In hemorrhagic glaucoma following thrombosis of central retinal vein, a cyclo-diathermy procedure may be tried first, but is often followed by an enucleation.

There are other less frequent types of secondary glaucoma, some of which are poorly understood and the results of surgery unpredictable. Frequently more than one type of operation will be necessary before the intraocular tension is controlled.

Summary

The surgical treatment of the various types of glaucoma has been surveyed. The major complications resulting from surgery have been discussed.

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Leukemoid Reaction in Escherichia Coli Pyelonephritis

REPORT OF TWO CASES AND REVIEW OF THE
LITERATURE

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and

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The term leukemoid was first introduced in 1926, by Krumbhaar¹, who reported 10 patients whose hemograms resembled leukemia. Hill and Duncan² later set down currently accepted criteria for the diagnosis of a leukemoid reaction. These consisted of (1) a total white blood cell count exceeding 50,000 per cubic millimeter, (2) 2 per cent blast forms, or (3) a combination of the two. Hilts and Shaw³ described the leukemoid reaction as a "non-malignant leukocytosis of such character as to present problems in differential diagnosis from true leukemia."

Although the actual number of authen-

ticated case reports in the literature are exceedingly few, several reviews of the literature have appeared^{2,3,4}. Since the differential diagnosis depends largely on its association with a disease known to produce a leukemoid response, and since such a response has not been reported in *Escherichia coli* pyelonephritis, the following case reports are thought to be of interest.

Case Reports

Case 1

A 63 year old male religious worker was in excellent health until three days prior to admission to Duke Hospital, at which time he began to have fever, malaise, vomiting, and anorexia. On the evening prior to admission, relatives

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found him wandering around in the cold weather, lost, and slightly confused. He was admitted the following day for evaluation. The past history was unremarkable as was the systemic review except for symptoms of prostatism of about one year's duration characterized by dribbling, frequency of urination, nocturia twice per night, and some hesitancy on starting the urinary stream in the early morning.

On examination he appeared confused and acutely ill, with a temperature of 102° F. The blood pressure was 110/80 mm. of mercury in both arms and the pulse rate was 120 and regular. The only other abnormal physical finding was a diffusely enlarged prostate with second degree induration. There was no tenderness of the costovertebral angle.

On admission a chest roentgenogram was negative. The initial hemogram revealed a hemoglobin of 12.8 Gm. per 100 cc., a white blood cell count of 135,000 per cubic millimeter, with a differential count of 2 stabs, 89 polymorphonuclears, 2 small lymphocytes, 1 large lymphocyte, and 6 monocytes. Two admission blood cultures were negative, but a urine culture grew numerous colonies of *Escherichia coli*. There was 2 plus proteinuria, but the urine was negative for Bence-Jones protein. The sediment contained 10 to 15 white blood cells, white blood cell casts, and occasional clumps of white cells per high power field. The patient was treated with Streptomycin for one week and chloromycetin for two weeks. A septic fever with daily spikes to 39 C. gradually subsided on the fourth hospital day. The white blood cell count only 24 hours after the beginning of therapy was 61,000 per cubic millimeter, with essentially the same differential as before. This value gradually decreased until the time of discharge when it was only 22,750. The bone marrow revealed an M/E ratio of 5.1 and was considered normal. Peripheral blood smears were always normal except for the presence of occasional myelocytes in concentrations as high as 4 per cent on several occasions.

Intravenous pyelograms and cystoscopic examination were normal except for obvious prostatic hypertrophy. A transurethral resection was performed without difficulty after the infection subsided, and the specimen was diagnostic of benign prostatic hypertrophy. Urine culture at time of discharge was sterile and the total urinary excretion of phenolsulfonphthalein in two hours was 60 per cent. The blood urea nitrogen was 19 mg. per 100 cc. Total proteins in the serum were 5.8 Gm. per 100 cc., with an albumin content of 3.0 Gm. per 100 cc.

The patient was readmitted a week following discharge because of abdominal pain, nausea, and vomiting thought to represent gastroenteritis secondary to prolonged antibiotic administration. He recovered in a period of two to three days after institution of large amounts of buttermilk.

He was then seen in follow-up six months later, at which time the hemoglobin was 14.1 Gm. per 100 cc. and the white blood cell count 14,200, with a normal differential. The urine revealed an alkaline pH, a specific gravity of 1.020, and no protein or sugar. The sediment was essentially normal. He was again in good health when seen one year following discharge. The white blood cell count at this time was 14,900, with a normal differential. The urine was again normal.

Comment

This patient presents a rather classic picture of acute pyelonephritis secondary to prostatic obstruction. To our knowledge this degree of leukocytosis has not been reported before in association with *E. coli* pyelonephritis. Although the hematologists initially suspected chronic granulocytic leukemia, the patient's followup course has been benign and it has become apparent that he most likely had a leukemoid reaction.

Case 2

A 37 year old Negro woman was admitted for vaginal hysterectomy and anteroposterior colporrhaphy because of urinary stress incontinence. Systemic review, past history, and family and social history were noncontributory.

Physical findings on admission included a blood pressure of 150/90 mm. of mercury and otherwise normal vital signs. There was a marked cystourethrocele and rectocele, but no other abnormal findings.

An admission white blood cell count was 13,000 per cubic millimeter. Urinalysis revealed a specific gravity of 1.028, and was negative for protein and sugar. Microscopic examination was also negative. The blood urea nitrogen on admission was 14 mg. per 100 cc.

A vaginal hysterectomy was performed two days later and an indwelling catheter inserted in the bladder. Approximately four days postoperatively the patient spiked a fever of 39 C. and the white blood cell count rose to 34,280, with 80 per cent polymorphonuclears, 5 per cent stabs, 8 per cent small lymphocytes, 3 per cent large lymphocytes, and 4 per cent monocytes. Urinalysis revealed 1 plus proteinuria, pyuria, and a urine culture grew out numerous colonies of *E. coli*. Treatment was started with Gantrisin.

A week following the onset of the infection, the patient was still febrile at 38.5° C. and the white blood cell count was 24,750, with 57 per cent polymorphonuclears, 2 per cent metamyelocytes, 1 per cent myelocytes, 33 per cent small and large lymphocytes, 2 per cent eosinophils, 3 per cent monocytes, and 2 per cent nonsegmented polymorphonuclears. The bone marrow was normal,

with an M/E ratio of 1:15. The patient was thought to have a leukemoid reaction secondary to *E. coli* infection. The blood count subsequently rose as high as 53,400 per cubic millimeter, with 2 per cent myelocytes being seen on peripheral smear. She was then treated with a course of chloromycetin and made a gradual but uneven recovery. At the time of discharge the white blood cell count had dropped to 16,480 per cubic millimeter. The patient was seen two months later, at which time a urine culture was negative and she was completely asymptomatic.

This is another example of a brisk leukemoid reaction secondary to *E. coli* pyelonephritis.

Discussion

Leukemoid reactions have been reported to occur in association with various diseases including malignancy⁵, pyogenic infection^{4a,6}, allergic reaction⁷, granulomatous infections, especially tuberculosis^{3,8}, and collagen diseases⁹.

Although leukemoid reactions have been reported in *E. coli* empyema¹⁰, and although pyelonephritis is alluded to by Valentine¹¹, no documented cases are included in his report. Perinephric abscesses and pyelonephritis were also mentioned by Heck and Hall^{4a}, but no bacteriologic data were given. To our knowledge, no documented cases of a leukemoid response in association with *E. coli* pyelonephritis have been reported. This is such a ubiquitous disease that the lack of association is quite surprising and presumably due to faulty reporting, for it is quite apparent that many actual leukemoid reactions are never coded as such, and are therefore missed (Hilts and Shaw³).

Hill and Duncan² have listed several possible mechanisms for leukemoid reactions: (a) bone marrow stimulation, (b) bone marrow liberation, and (c) ectopic formation of hematopoietic elements. Hilts and Shaw³ commented on the importance of the lungs as a possible clearing factor for the blood stream, and postulated that in severe lung disease such as tuberculosis, white blood cells might not be cleared rapidly enough by the lungs and therefore a greater number would appear in the blood stream. This obviously does not apply in the majority of case reports. The literature is devoid of any real experimental work on

the production of this syndrome with one or two exceptions¹², and mechanisms are still obscure. The extreme variety of reported cases forces one to conclude that almost any agent can precipitate this type of response in the appropriate patient. Attention is therefore focused away from precipitating causes and on the individual responses to various stimuli. This point is probably best exemplified in the literature by Ward's¹³ study of a family which included 3 cases of leukemia and one with a leukemoid reaction. The patient with the leukemoid reaction has been followed for 18 years now, while the brother, aunt, and distant relative all died with documented leukemia. One cannot escape the impression that certain people react to stimuli with leukocytosis and that the clue probably resides in the individual response rather than in the precipitating agent.

Differential diagnosis

The differential diagnosis of a leukemoid reaction, and particularly its differentiation from leukemia, is always difficult and depends on several factors: (1) the presence of a known associated illness such as tuberculosis or malignancy; (2) adequate follow-up; (3) the results of various biochemical tests. Blood histamine values have been reported as being high in chronic myelogenous leukemia and normal in leukemoid reactions¹¹. Alkaline phosphatase levels in white blood cells are reported to be increased in leukemoid reactions and decreased in leukemia¹⁴. Other differential points which have been mentioned in the literature include the degree of immaturity of cells, the extent of the leukocytosis, and the presence or absence of splenomegaly^{4a,6}. It is to be noted that by far the most reliable of the above criteria is that of adequate follow-up, for often in the acute stages it is impossible to make a definite diagnosis. This fact is well exemplified in the following case history from our files.

A 74 year old man was admitted to Duke Hospital with massive gastrointestinal hemorrhage thought to be secondary to esophageal hiatus hernia. The white blood cell count at this time was 36,375 per cubic millimeter, with 2 per

cent metamyelocytes and 1 per cent myelocytes in the peripheral smear. A bone marrow was normal on examination. He was thought at the time to have a leukemoid reaction to severe hemorrhage, and was followed subsequently. The leukocytosis remained persistent even when the hemoglobin was normal. A definite diagnosis of chronic myelogenous leukemia was not made until 15 months after the patient was first seen, at which time the white blood cell count was 74,750 per cubic millimeter with blast forms predominating in the peripheral blood smear. It is true, however, that this patient's white blood cell count never returned to normal as it usually does in patients with true leukemoid reactions.

Summary

Two cases in which leukemoid responses were secondary to *E. coli* pyelonephritis are reported. The importance of the host response rather than the precipitating cause is emphasized and the value of long term follow-up stressed. Difficulties in differentiating leukemia and leukemoid reactions are restated, with discussion of a case thought initially to be a leukemoid reaction which subsequently developed into acute leukemia.

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A Problem of Insulin Dosage

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A major and often perplexing problem presented by the diabetic patient is that of optimal insulin dosage. Despite broad differences in viewpoint concerning the permissive versus the restrictive control of diabetes, it is generally agreed that adequate management should permit the avoidance of the symptoms of both hyperglycemia and hypoglycemia.

The symptom-complex resulting from sustained hyperglycemia includes thirst, polyuria, and weight loss. That symptoms of a more subtle variety, in the absence of the aforementioned ones, can be recognized by the diabetic patient and related in some manner to hyperglycemia is doubted by many. The symptomatic consequences of hypoglycemia, which have been well described by Goodman¹, are rather characteristically *episodic*. While the typical weakness, sweatiness, and hunger may be absent, especially with the long-acting insulin preparations, headache, mild jitteriness, and a host of other subjective complaints may be associated with hypoglycemia. Neurologic symptoms, behavioral disturbances, epileptiform seizures, and coma may occur. Structural and functional damage to the central nervous system has been demonstrated following prolonged or repeated bouts.

Less widely recognized but of major importance is a further consequence of insulin hypoglycemia in the diabetic patient, that of "rebound hyperglycemia," often with mild keto-acidosis, which may occur within a few hours following hypoglycemia. The concept of impaired carbohydrate tolerance resulting from insulin hypoglycemia was documented and popularized by Somogyi²; its pathogenesis is not clearly defined, but in all likelihood relates to an "overshoot" of the homeostatic mechanisms which are mobilized when the blood sugar reaches abnormally low levels. This "overshoot" is pronounced in the diabetic, since the mobil-

ized carbohydrate is but slowly utilized in the absence of available endogenous insulin. Some of the mechanisms which induce this condition may be: (1) the elaboration of epinephrine, which decreases the utilization of glucose and increases glycogenolysis; (2) an increased secretion of hydrocortisone from the adrenal cortex, which enhances gluconeogenesis and, together with somatotrophin, contributes to the formation of an insulin-binding lipoprotein and an albumin-bound anti-insulin factor; (3) increased release of glucose from the liver due in part to glucagon effect and in part to the direct action of hypoglycemia on hepatic cells; and (4) the appearance of an alpha globulin-bound anti-insulin factor when keto-acidosis has occurred. It is to be noted in particular that a number of factors which induce insulin resistance have now been identified (excluding those of a known immunologic character); the evanescent fashion in which one or more of them appear and disappear indeed complicates the precise understanding of a given clinical situation. The recognition, however, that insulin resistance of variable severity and duration often succeeds a bout of hypoglycemia, is highly useful in approaching such an understanding.

Ironically, the hyperglycemia which succeeds the hypoglycemic bout is often construed by patient and physician alike as indicating the need for more, rather than less, insulin. This circumstance may well produce a widely fluctuating clinical and chemical state often described as "brittle diabetes." It therefore behooves the physician correctly to interpret poor control, as evidenced by marked glycosuria and mild ketonuria, as *either* too little or too much insulin. This discrimination may be exceedingly difficult on occasion, the problem often arising in the non-obese diabetic regulated on repository insulin in excess of 40 units per day.

Though no simple and easy device for

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achieving the desired discrimination can here be offered, certain observations may be helpful.

1. A symptomatic *history* of episodes suggestive of hypoglycemic bouts followed within hours by a tide of glycosuria is highly suggestive of hyperinsulinism. Reference has been made to the variable character of such symptoms, and it is worth while to seek a history of any sort of episodic, recurrent symptoms. It is possible and perhaps likely that hypoglycemia may occur during sleep in some patients and be thereby symptomatically masked. Once a pattern of episodic symptoms is discerned, an effort should be made to correlate temporally the chemical findings. This is often a most difficult exercise. Recent and sustained weight gain may on occasion represent a clue that excessive insulin is being administered.

2. From the *pattern of glycosuria*, one may often obtain evidence suggestive of this phenomenon. A key finding which should alert the physician that bouts of hypoglycemia may be contributing to poor diabetic control is that of widely fluctuating urinary sugar values. The testing and recording of pre-meal and bedtime specimens (discarding the overnight collection) facilitates this observation. Particularly suggestive is a late afternoon or mid-evening negative specimen followed by a pre-breakfast value of 4 plus. With NPH insulin, the urine may become free of sugar in the late afternoon or mid-evening; with Protamine Zinc Insulin, the negative specimen is likely to be found at bedtime or during the night. The abrupt change from negative to strongly positive suggests, but does not prove, the existence of a rebound mechanism. Although a daily fluctuation is the usual finding under these circumstances and is ordinarily not dif-

ficult to recognize, it should be noted that the duration of insulin resistance is highly variable and may on occasion persist for days instead of hours. The prolonged variety is more difficult to discern as having related to the previous administration of insulin; furthermore, efforts to reduce the insulin dosage during this period are likely to be unrewarding. The only way to deal effectively with this difficult set of circumstances is to perceive its nature; gentle and gradual reduction of insulin may then be tried as sensitivity to insulin returns. The pattern of glycosuria is useful only when it reflects with some faithfulness the blood sugar. This is often not the case where significant renal disease exists.

3. The documentation of an episode of hypoglycemia by obtaining a blood sugar at the expected or the observed symptomatic time is most helpful. It may on occasion be judicious to hospitalize the patient and obtain blood sugar observations at two-hourly intervals throughout the day.

Although here concerned primarily with the recognition of inappropriate insulin therapy, one cannot omit a reference to the need for correct timing of the caloric intake with relation to insulin administration. Patients on NPH insulin should receive a mid-afternoon and bedtime feeding; patients on PZI should take a bedtime feeding. The prevention of hypoglycemia by appropriate dietary measures may permit the avoidance of the syndrome herein discussed.

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Have you noticed that young children and their grandparents form a mutual adoration society? That, although they may seldom meet, they talk a great deal about each other? And that, when they do meet, an almost secret understanding between them? One is in Grandma's arms, the other in Grandpa's, and almost no time they are out of sight, chattering as they go like old members rejoining. (Reprinted from *Parents*, England, June, 1960)

Exhibitionism

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The purpose of this paper is to present our experience with exhibitionism in the Outpatient Clinic of the Department of Psychiatry at Duke University.

Exhibitionism is defined by Rickles as, "a pathologic condition characterized by a compulsion to expose the male genitalia periodically for the relief of inner tension, an act seemingly incongruous with the rest of the individual's personality." The condition was first described in medical literature by the French neurologist, Charles LaSague, who named it exhibitionism. LaSague later established what he called the scientific characteristics of the phenomenon. Prior to this writing exhibitionism was considered to be the concern, not of medicine and psychiatry, but of law enforcement agencies.

Exhibitionism is the most common of all sex offenses, accounting for 35 per cent of all arrests for sex offenses in one series compiled by the Psychiatric Institute of the Municipal Court of Chicago in 1942. Exhibitionists rarely have criminal records. There is no evidence of progression to more serious sex crimes.

Exhibitionism is a disease of males. In all the literature only one female offender has ever been reported, and she was discovered to be severely mentally defective.

In spite of its prevalence, the literature on exhibitionism is singularly sparse, and the general attitude appears to be one of neglect.

Presentation of Cases

Of the 6 patients presented here, 5 were seen originally for psychiatric evaluation at the Psychiatric Outpatient Clinic at Duke University Hospital from July 1, 1959, to January 1, 1960. All five came voluntarily; all were male; all had determined to seek

treatment as a result of encounters with the law. Ages ranged from 22 to 26. The sixth patient was seen originally as an inpatient at the John Umstead Hospital and followed in outpatient therapy at the Duke Clinic.

Case 1

The patient was a 25 years old white married male. Several weeks prior to admission he had been apprehended by the police for indecent exposure, and had been placed on probation by a local magistrate with the recommendation that he seek psychiatric treatment. He came at the suggestion of the judge, but felt that his apprehension by the police had "broken the urge."

His exhibitionistic behavior had begun in 1953, in Germany, when he noted people urinating in the streets. He himself adopted the practice but then had the urge to expose his penis to women, especially char women. After the act he would retire to some private place and masturbate. In Germany he exposed himself about once a month. During this period he was having sexual relations two or three times a week. This continued during the entire 18 months he was in Germany. On his return home he tried to stop, but found he could not. He found the urge quite irresistible, and began driving to secluded spots and exposing himself to white women between the ages of 20 and 40. After doing so, he would masturbate and for a time feel more relaxed.

The patient is the second of three siblings. His mother died in 1956 of a long-standing infection of the bone, presumably the result of dental extractions. She had had some 20 operations for this condition, and was in almost constant pain, requiring medication daily. In spite of this fact, she continued working in a tobacco factory until her death. His father, especially in his early years, drank heavily, losing two houses and a cash inheritance as a result.

The patient's early life was difficult. There was enough to eat, but the food was usually canned and poorly prepared because of the mother's poor health. The patient considered himself to have been his mother's favorite, since he helped her with the dishes and went with her to the doctor.

The patient was shy and had few dates before entering the service. He was frightened of people, especially girls, and when first seen tended to keep to himself. In high school he felt that he did not have the advantages of the other students. He was concerned about his clothes,

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From the Department of Psychiatry, Duke University Medical Center, Durham, North Carolina.

and on occasion would go home during the day and change. He never felt equal to other people. He could not relax and constantly felt compelled to do something. His chief interest was athletics, at which he attained considerable proficiency.

His wife was 3 years his junior. They have a daughter 2 years of age. The wife knows nothing of her husband's sexual problem.

Case 2

The patient was a 24 year old white man who was separated from his wife. His father, who knew of his problem, had strongly urged him to come to the clinic. Sometime later he was apprehended for indecent exposure. He was placed on probation by a local magistrate and urged to seek psychiatric treatment.

The patient's exhibitionist behavior began about five years before admission, in cooperation with an aunt who was three years his senior. They would expose themselves to each other across the sitting room while carrying on an unrelated conversation. The flow of talk was uninterrupted. The patient had the impression that his aunt was seeking intercourse, but he had no wish to comply. After such an episode he would leave the room and masturbate.

A little later he began exhibiting himself at the window of his home, and on occasion would drive out to a secluded spot and expose himself to a woman from his car.

The patient was married in 1957, but after a few months he became aware that he and his wife were ill-matched. They lived with her parents who, along with her brothers, treated him with the utmost disdain. The patient, who had stopped for a time after marriage, began exhibiting himself again, on one occasion to his sister-in-law. At this point the family became aware of his problem and his own father forcefully urged him to accept treatment. Following this conversation the patient exposed himself to a Negro woman in a local park, and was arrested.

The patient is the eldest of three boys. He was somewhat of a braggart as a child, feeling it necessary to emphasize his superiority over his brothers in strength and athletic ability. He described his mother as the type of woman he would like to have married. All three boys customarily brought their dates home to be chaperoned by their mother. The father has had three nervous breakdowns following a ruptured disc. In addition, he has been addicted to narcotics.

The patient has a spotty work history. He has worked as a window decorator, is interested in art, and has worked as a fireman. At the time of the initial psychiatric evaluation he had returned to work as a cobbler in his father's shop.

Case 3

A 25 year old, white married man was referred to the Psychiatric Outpatient Clinic from

the Durham VA Hospital, where he had been hospitalized following arrest for indecent exposure and a recommendation to seek psychiatric treatment.

His illness began in the summer of 1959, when he began driving around looking at clothes lines, especially those hung with women's clothes. During the same period he learned that his wife was pregnant. This news surprised and distressed him since he had been told at age 18, after an episode of mumps orchitis, that he would never be able to father children. The patient exhibited himself on only one occasion, in October, 1959, to two girls, asking, "Have you ever seen anything like that?" Following this episode he was apprehended.

The patient's father is in his seventies and in good health. His mother, who is in her fifties, has high blood pressure and has had several heart attacks. His father has been married three times, being twice a widower. His mother, the third wife, bore two children, the patient and an older brother, aged 27.

The patient did not walk until the age of 3. He was somewhat shy, and did not graduate from high school until the age of 19. One year before enlisting in the air force he was treated by his family doctor for "nerves," and one month after enlistment he was hospitalized for 10 days, again for nerves. His marriage is apparently reasonably happy. His wife knows nothing of his sexual problem.

Case 4

A 26 year old white married male was referred for psychiatric evaluation by his attorney following arrest for indecent exposure.

His exhibitionistic behavior, consisting of three or four episodes, began in February, 1959. The pattern was at all times similar. He would note a young girl, usually an adolescent, walking along the road, and would ask her to ride with him. Most often she would refuse. At this point he would show her his penis and ask if she would like to play with it. When she quickly turned or walked off, he would hurriedly drive away. His first reaction was a feeling of strength and power. This would be followed by overwhelming guilt, with the belief that somehow he had damaged the girl for life, and that as a result of her experience she would never be able to be happily married. On no occasion did any girl accept his offers, and he remarked, "I don't know what I would do if they did." His main goal was to see the shocked expression on their faces when they saw his penis. He did not masturbate at any time during the act.

The patient steadfastly denied the episode for which he was arrested, although he admitted being at the places he was reported to have visited.

The patient had had a penile lesion, diagnosed

as Peyronie's disease, in 1955. At this time a fibrous mass was removed from the penis. The condition recurred, but he did not return to his physician out of fear of mutilating surgery. The lesion has made sexual relations with his wife difficult and painful.

The patient is one of seven siblings, six boys and one girl. A younger brother was arrested for stealing, skipped bond, and has not been heard from since. Another brother, described as a "drifter," has been married twice and has a problem with alcohol.

The patient describes his mother in glowing terms. He always wanted to do things for her and still frequently buys her presents on his trips as a salesman. He feels obligated to her for all she did while he was growing up. His father kept a mistress all during the patient's early years, and gave her most of his money. The mother made out with what was left. She often said she was fed up with her husband, but never left him.

The father is described as belligerent, hostile, demanding, self-centered, and cruel. He supported his mistress in better style than he did his family. The patient goes home only when his father is away.

The patient has been troubled with migraine since reaching the age of 16, at times so severe as to require hospitalization. He is married, but has no children. The wife knows of his difficulty and has promised to stand by and help him all she can.

Case 5

A 26 year old white male was referred to the clinic by the dean of Duke University after being arrested for indecent exposure. His exhibitionism had begun as voyeurism in 1955, when he was a college student. He, his wife, and child were living with his mother-in-law. Across the courtyard from his bedroom two girls, aged 10 and 7, had their room. At first he just watched them undress. This habit progressed to watching, followed by masturbation in private, and finally to exhibiting himself to the young girls. Only one, the seven year old, remained interested over the month that the practice was carried on. At the same time the patient also exhibited himself as he drove at high speed, to and from college. He never had the assurance that anyone saw him as he drove by, but he hoped that someone had.

In September of 1959 he entered graduate school, and in November, 1958, began a new practice. Whereas he had had previously exhibited himself in a fast moving car, he now parked outside a junior high school during lunch hour and at school closing and exhibited himself to the young girls as they came out. He was not arrested until February, 1959. He first tried to deny his behavior. It could not have been he

who had committed this act. When he did finally confess, however, he was reduced to a state of extreme guilt and panic.

The patient is one of six siblings. At the age of 4, he began indulging in sex play, in secret, with his next older brother and sister. The sister terminated the play on entering puberty. Sex play with two older brothers continued up into the teens, with the patient being used passively *per ano* or being compelled to perform fellatio. He was greatly interested in pornographic literature and masturbated frequently, with fantasies of possessing an enormous penis. In addition there was some sexual activity with animals.

The patient's oldest brother, now divorced, lives a solitary existence—embittered, resentful, and alone. An older sister left home at the age of 17 to "escape the unhappiness at home." The youngest brother has been in difficulty with the law for having passed some bad checks. Another brother, recently married, has had numerous homosexual experiences.

The mother is an aggressive, domineering woman who subjugated her children until they could stand it no longer and escaped. The patient did not escape. He felt sometimes that he did not have a separate existence at all—that he was merely an extension of his mother. She loved him, but only insofar as he pleased her. He felt he owed her everything, and that without her he was nothing.

The father was an alcoholic who early gave up all authority in the family. He made good money, but before his wife took over the management of affairs he squandered it. Finally she threatened to leave; he capitulated, let her take charge. In the month prior to the patient's arrest, however, a shift in the family occurred. The father became more aggressive, resumed control over the household, took over the management of the finances, and refused any more money to his son (the patient). This change coincided with the change in the patient's exhibitionistic pattern. The patient is married, and has four children. His wife knows of his difficulty and has pledged her help and support.

Case 6

The patient was a 22 year old white male who came as a voluntary patient for admission to the John Umstead Hospital. He had been arrested by the police of Greensboro, North Carolina, for indecent exposure and assault on a female. He was evaluated as an inpatient and continued in outpatient treatment at the Duke Outpatient Clinic.

The arrest actually stemmed from the second charge. The patient had gotten out of his car, approached a girl, and asked to have intercourse with her. When she refused he drove off, but she had taken his license number, and he was ar-

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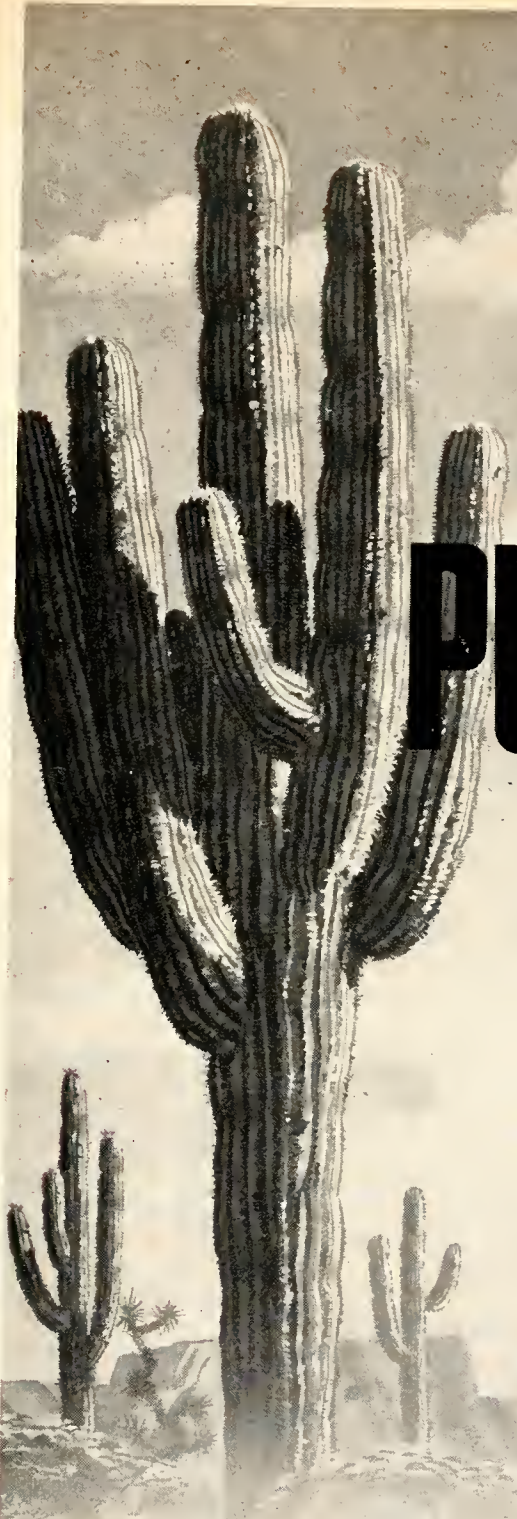
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rested. He had for several months been driving around the city at night exposing himself to women. This, too, had been reported to the police, but no action was taken until the episode termed assault on a female. The patient was then confronted with his other activities. He confessed to everything. He was brought to trial and given a two-year suspended sentence, but was probated five years on condition that he seek psychiatric treatment.

He began to have weekly sessions with a psychiatrist in Greensboro and was doing reasonably well until quite suddenly his wife's mother and brother came to their home and took his wife and baby away, on the grounds that he was not a fit husband and father. Being rather passive and feeling very guilty, he did nothing but let his child and wife go. He soon began exposing himself again, and was prey to considerable anxiety and guilt. It was on the suggestion of his psychiatrist that he came to the State Hospital.

The patient had begun his exhibitionistic activities a few weeks before his marriage. He was compelled to marry the girl he had been going with because she was pregnant, although he had decided in his own mind to do it anyway. About two weeks before the wedding he had an intense desire to have intercourse with some other woman. He drove around the city a number of times and approached several women, but was refused. Then he conceived the idea of exposing himself. Characteristically he would drive up in his car beside a woman on the sidewalk, open the door and expose his erect penis. If she saw it, no matter what her reaction was, that was enough. He then drove off, and usually masturbated. Very seldom, if at all, did he get out of the car and request intercourse. He only wanted her to see his penis, and when she had done this he was satisfied. If she did not, then he must find somebody who would. He often carried out this routine several times during the night. Since the first he had done it more than one hundred times. During this entire period he was married and apparently had a satisfactory sexual adjustment with his wife. Nevertheless, in his fantasy life one woman was not enough—he must have several; so his compulsive exhibitionism continued.

For the patient, exhibitionism was one impulsive self-destructive act in a lifelong pattern of maladjustment. Up to age 11 he was docile, obedient, and close to his mother—indeed quite dominated by her. After 11 the fury within him burst forth, and from then to his entrance into the armed services he was bad-tempered, obnoxious, headstrong, and sexually precocious. The excessive preoccupation, along with social maladjustment, began in this period. He felt isolated and lonely and repelled by others. He wanted very much to be with girls, but they repulsed him. In fantasy he was a Don Juan; in reality he had little success. At 11 he lost all in-

terest in childish things and, as it were, was transformed, or so he fancied, into an adult. This premature yearning for maturity was born of a conviction that children were deprived, unwanted and unloved, for such had been his experience. He wanted no more of such a helpless and unfulfilled dependency.

After his discharge from the service he again became docile, quiet, and withdrawn. His former fury gave way to despair. He lost much of his fight. What he wanted he was sure he would never get. There was little reason to struggle. He felt trapped, especially on learning that he was going to have to marry a girl whom he had made pregnant. His only escape was the daring, impulsive, self-destructive act which he hit on and which brought about his arrest.

The patient's mother was an attractive, openly cooperative woman. From her he had developed a profound hatred for and an equally profound need of women. The mother, by her attitude and behavior, had succeeded in belittling and reducing her husband's masculine role, and had attempted to do the same with her son until he was 11. She managed to involve herself in his life, and indeed there is some suggestion that she was rather over fond of bathing him and fondling his genitalia when he was a small boy. She was most anxious to help in his present predicament, but she could not leave her hands off him, his wife or their marriage.

The patient's father was a good-looking, quiet, passive, man. He had been reduced to a state of impotence by his wife. To maintain some vestige of masculinity, he had adopted over the years, a scornful, belittling attitude toward his son. He had given him little encouragement. He seemed to have feared the competition of his son and kept his distance.

The patient's wife, who knew of his difficulty, was young and inexperienced at loving. If she had any faults it was that she tended to follow the example of his mother in not allowing him to make decisions for himself. She has pledged her support to help him overcome his difficulty.

Discussion

In discussing these cases, we would first like to give what might be considered a composite picture of the exhibitionist by grouping the findings under three headings: (1) the exhibitionistic behavior itself; (2) developmental factors, and (3) the marital history. Second, we shall discuss the treatment of the exhibitionist, and finally we shall remark on the medicolegal aspects of this syndrome.

Without exception our patients' behavior came to the attention of the police. Without exception in all 6 cases the act was carried

out, at least in the beginning, from a car. In all but 2 cases nothing was said to the women involved, and in one of these the remark was: "Have you ever seen anything like this?" In the other case, a questionable attempt was made to seek sexual relations. In all but one case the act of exhibiting was followed by masturbation. In all but one the act was performed in a secluded, dimly lit area.

In those cases where information was available, it was clear that an attitude of surprise, excitement, even awe, on the part of the women approached was sought. Indifference or scorn was shattering, crippling, and called for repetition of the act.

Along this line an amusing incident was told to us by a police informant. A group of secretaries were walking along a subway concourse on their way to lunch when suddenly a man leaped out from behind a pillar and exhibited himself to them. Instead of the anticipated shock, one of the girls giggled, "Oh look at that little thing!" The exhibitionist turned and fled in anxious confusion, running into the arms of a near-by policeman.

Careful investigation of the occasion for the patient's arrest indicated a number of differences between this and preceding episodes. There seemed to be less caution, more abandon—almost a wish to be caught. The patient took more risks—for example, getting out of the car and approaching a woman, openly addressing young girls, calling attention to the act, exposing himself to numerous high school students in daylight hours. The episode resulting in arrest seemed also to be preceded, at least in some cases, by a traumatic experience or a significant event. In one case there was a lecture by an aggressive parent prior to the experience. In another, there was loss of wife and child. In another, there was a change of roles in the mother-father constellation. In another, there was notification of coming parenthood.

Arrest brought, in general, a feeling of great shame, humiliation, and guilt. In 2 cases there was partial amnesia of the act for which they were being arrested. There was evidence in 2 cases of gross sexual

abnormality prior to exhibitionist behavior, and considerable shyness, modesty, and hesitancy in heterosexual adjustment in the other 4. The exhibitionistic activity began in one case under stimulation from an aunt; in another as a kind of fetishistic preoccupation with women's garments; in another as a scopophilic interest in 2 small neighbor girls, and in another as a substitute for intercourse.

Role of the parents

In general, the mother was found to play a very significant role. This was clearly expressed in case 5, in which the patient felt himself to be not even an independent person, but an extension of his mother. The mothers tended to be openly domineering or covertly subjugating. Attachment to and identification with mother was common. In some cases the mother had fondled the genitalia of the child for prolonged periods.

The father was, in general, ineffective. He was most commonly neurotic and occasionally alcoholic or addicted. He played a distinctly secondary role to the mother. The patients generally admired their mother for her strength and courage, and deplored the weakness of their fathers. Exhibitionism tended to be a *folie à famille*. Not that there were multiple instances of exhibitionism in a family, but rather evidences of other types of maladjustment in siblings. These included criminality, homosexuality, bestiality, and alcoholism.

Developmental factors

In general, the development of these patients had been abnormal. Most were shy and retiring, and all had had difficulty in heterosexual adjustment. There was a history of bed-wetting and stuttering in one, of precocious puberty in another. School was a time of stress for all. All were ill at ease and had dated little. School work was, however, average or above. All had secured reasonable employment, although there seemed to be a pattern of multiple jobs.

All 6 patients had been married, and only one at the time of interview was separated and headed for a divorce. Of the wives who were aware of their husband's problem only

one failed to stand by him. Of all the wives, only one had been unfaithful to her husband during the marriage. She was the one who had left her husband and was contemplating divorce. Marital adjustment was in general good.

Results of treatment

Of the 6 patients, only 2 became actively involved in psychiatric treatment. Of the remaining 4, one said that apprehension by the police had "killed the urge." The other 3 appeared to be more interested in obtaining the doctor's help in securing release from probation than in investigating the cause of their exhibitionistic behavior. They soon dropped out of treatment.

Failure to continue in treatment seemed to be related to two factors; family interference and lack of patient motivation. Insofar as the patient's family, in particular the wife or mother, were either ignorant or critical of his problem, and in so far as these two crucial figures refused to cooperate in efforts to help him, the prognosis for continuation of treatment was poor. Out of ignorance or antagonism, they tended to perpetuate the same behavior which had laid the foundation for exhibitionism. Such mothers tended to remain overly involved with their sons. They openly expressed a wish to help, but were unable to let go their crippling hold. Wives tended to ape the mothers in belittling and subjugating their husbands. In some cases these women fostered open antagonism to the doctor, in others, covert hostility negated the efforts of anyone else to help him. He would come to see therapy as a threat to his relationship with these needed figures and would drop out.

Also related were factors of personal motivation. Since all patients came because of encounters with the law, coercion of itself could not be explained as lessening motivation. What seemed more to be involved was dependency on family approval and an inability to form significant relationship outside of the family. These patients had never revealed themselves to anyone, even their wives. They remained suspicious and aloof. As unsatisfactory as their family relation-

ship was, it was all they had been able to attain. Therefore, they were dependent upon it and afraid to give it up. Displeasure of family figures and failure to make significant relationships outside the family combined to make therapy appear a threat to be avoided.

Of the two who became actively engaged in therapy, one improved sufficiently to be dismissed, and one continues in treatment. Of great significance in instituting treatment and bringing it to a successful conclusion was the proper handling of the families. In both cases the wife accepted individual therapy for herself. In the case which came to successful conclusion, the mother and father were also seen in individual sessions. The effect of separating these significant figures, in particular the wife and mother, from their pathologic involvement in the patient's life was in itself remarkable. This gave the patient the feeling of needed family support, at the same time leaving him free to work out his own destiny.

Both patients were initially very suspicious, unaccustomed to revealing themselves, unsure that anyone anywhere respected their individuality. So ineffective had their fathers been that the therapist, himself a male, found one of the initial stumbling blocks to be transference of the the patient's expectations of ineffectuality. If father could do nothing against these women, what could another man do? Treatment of the wife and mother had the additional advantage of proving the therapist's ability to deal with these women. With this obstacle overcome, and with the needed support of a strong male figure, the patient was able to carve out for himself a personality distinct from that of the all-encompassing mother. This new-found individuality led to devaluation of exhibitionism as the supreme expression of aggression. The patients learned to give vent to their masculine strivings in more socially acceptable ways. They came to appreciate hitherto unconscious facets of their personality such as creative urges, thirst for knowledge, and ambition. They remained interested in family and friends, but now as equals.

After the initial transference problems centering around the impotence of father, the therapist was seen as guide and friend. As progress continued, however, the more deeply unconscious threat of the father appeared, the sleeping giant who concealed fierce competitiveness and aggression toward his son, and who could not allow his son to achieve the independent relationship with women he himself had not achieved. The image of the jealous father was also transferred to the therapist. With the working through of this distortion, therapy was on the way to termination. The patient had carved out an existence separate from his mother, and not subject to the threatened hostility of his father.

Summary and Conclusions

1. It is of crucial importance to involve the mothers and wives of these patients very early in the course of treatment, whether it be through social case work or individual psychotherapy. If possible, the father should also be encouraged to become involved. His role, however, is of less importance, and his failure to cooperate is not as crucial as that of the most significant female.

2. Continuation of treatment to a favorable outcome will depend to some extent on the patient's ability to form relationships outside of the family. Insofar as the patient has, however feebly, managed to see women as other than threatening, has made a reasonably happy marriage, and has a cooperative wife, the chances of improvement are increased. These factors reflect a readiness to reveal himself, albeit poorly developed, which can be used by the therapist.

The initial therapeutic problem is the transference to the therapist of the ineffectuality of the male parent. Later the more difficult transference distortions related to the jealous father are encountered. Because of the nature of the involvement with female figures, it would seem impossible for anyone but a male therapist to treat these patients.

4. The therapy proceeds as the patient,

with the support of the therapist, begins to separate himself from his mother, and to give expression to his masculine strivings in more socially acceptable ways.

5. It is important to make clear in the beginning and throughout the course of therapy, as need arises, the harmful effect of further exhibitionistic behavior. If the therapy develops in this manner, the problem of probation and its meaning to the patient becomes secondary. Initially it may be used as a defensive maneuver against active participation in therapy, the attitude being, "Why should I talk about all these things when tomorrow a policeman may knock on my door and take me away to prison." As the patient feels himself changing and assuming more control over his destiny, probation will scarcely be mentioned. Later on, as the jealous father transference emerges, probation fears recur until this problem is worked through.

We have mentioned that all 6 patients came to our attention as a result of encounters with the law. Treatment of this condition, then, requires careful and continued cooperation between the doctor and the court. We are witnessing in these days a more understanding handling of these offenders by the courts. Apparently the day of imprisonment as the sole method of handling these patients is passing. On the other hand, we believe that probation with strong urging to seek psychiatric treatment is not always enough. Often psychiatric treatment is not sought and the opportunity to note other disease or at least to attempt therapy is missed. We have seen one patient whose exhibitionistic behavior coincided with a latent schizophrenic process, and another with a dangerous pedophilia. Often the exhibitionistic behavior cannot be treated without incarceration, and obviously the help of the court is necessary in such a move. We are of the opinion that all sex offenders should receive a careful psychiatric evaluation and that treatment of such offenders should be a cooperative effort between doctor and law enforcement agencies.

Why a Part-Time Physician In Industry?

BENJAMIN W. GOODMAN, M.D.

HICKORY

To most of the world—and to many Americans—the United States appears to be preeminently a nation of large industries. But more than 99 per cent of all the establishments under the Old-Age and Survivors Insurance Program of the Social Security Administration employ less than 500 workers, and recent surveys indicate that small businesses are on the increase. Employees of small businesses today represent approximately two thirds of our entire labor force.

The problem before us today as general practitioners of medicine is to devise and provide an adequate occupational medical program to reach this vast number of employees who, in most instances, have no access to industrial medical facilities.

What is the basis for this statement and these ambitions? The poet Edwin Markham gives us this clue:

Why build these cities glorious
If man unbuilted goes?
In vain we build the world
Unless the builder also grows.

Occupational medicine as an approved specialty was just five years old in February, 1960. As yet, only six medical schools in the United States offer academic training for certification in this specialty, and less than 400 physicians are certified to practice it. At last count, 40 State Public Health Services have instituted programs of occupational medicine. Because training of specialists through academic channels is a lengthy process, staffing of this mushrooming practice must depend largely on the part-time efforts of the general practitioner.

I consider the most significant determinant of the scope and effectiveness of an occupational health program to be orientation of the doctor or nurse. To a great many, probably a majority, of doctors and nurses today industrial medicine means simply the

treatment of industrial injuries. When such physicians and nurses are brought into industry, their programs are usually quite limited. If, on the other hand, they are aware of and understand the objectives and techniques of preventive and constructive medicine, even though they may be working only part time, they can bring to a small plant a health program of the caliber usually found only in large industrial programs.

Admiral Ben Moreell had a deep perception of the value of industrial medicine. He knew the health services, and especially the environmental health service, which made victory possible in the battle of the South Seas. He approached this question in a speech, in 1955, as follows:

A good industrial medical program has as its prime purpose the elimination of hazards to the health of its workers. The target is prevention. This requires detection of current and potential exposures in the work environment; health education; individual worker counseling; competent craftsmanship in medical work; rehabilitation; protection of the community pollutions; cooperation with the general practitioners in the community; and adaptation of industrial medicine to the total life and public health activities of the community.

Prevention

Let us briefly expand the idea of prevention. To begin with, it is less expensive to prevent than to repair the effects of accidents and breakdowns, whether they occur in material and equipment or in the work force. Modern business and industry have accepted the concept of preventive maintenance of equipment. It has been repeatedly demonstrated that it is good business to prevent waste, breakdowns, and accidents. Let us, therefore, apply the same logic to maintenance of health.

Perhaps the most important reason for an effective occupational health program today is the early detection and prevention of illness and disease. Here is the big payoff! Many of the techniques of prevention, meager as they are, can be applied through

Read before the Section on General Practice of Medicine, Medical Society of the State of North Carolina, Raleigh, May 11, 1960.

programs of periodic examinations. Such programs have become very popular at the executive level in most of our larger industries. Their economic cost is generally accepted as protection of investment in high-priced manpower. The yield from periodic examination is about one in five—meaning one new unknown, or previously known but neglected, disease in five examinations.

Dr. Logan Robertson has stated that "there is an impressive consistency in which at least 15 per cent and up to 40 per cent of those examined are found to have a significant disease or defect of which they are unaware. In as many as one half to two thirds of the cases, these disorders are without symptoms when so discovered."

We have dealt at length with the importance of a good occupational health program, the proper orientation of physician and nurse, and preventive measures through periodic examinations, but I am sure this is not the problem common to most of us today. The big hurdle, as I see it, is to stimulate the interest of the owners and operators of small industries. Many of us—indeed a majority of us—have frequent contacts with companies which have no interest (or who have shown none) in pre-employment examinations, much less periodic examinations. Someone, therefore, must do the job of educating and selling industry on the importance of an occupational medical program. Medical ethics has not yet reached the point that you and I can go out and promiscuously sell our medical program to industry. If, however, representatives of industry seek guidance or advice from us, we are in a position to familiarize them with the importance of an adequate occupational health program.

It is hoped that more information from such sources as the Industrial Medical Association and the American Academy of General Practice will stimulate interest in health programs among small industries. The lack of information and understanding is the greatest deterrent to small plants.

The problem is not always a lack of motivation on the part of industry, however. A doctor with Prudential Insurance Company relates this story:

Some 15 years ago, a situation occurred in New England, where there were ten plants all located in close proximity. Each had fewer than 90 employees, and all were quite willing to go ahead and pay an attractive salary to a part-time physician to operate a cooperative health service for the group. Despite their motivation they canvassed their entire area and could find no doctor interested in undertaking this challenging task. It is stated that to this day the motivation of these plant executives has remained high, but no physician has yet been found willing to commit himself to this much needed and well conceived project.

In the face of such experiences, many an enlightened executive in smaller companies has felt forced to drop or postpone his hope of gaining the benefits that an industrial health program can provide. But by no means have all industrialists accepted these difficulties as insurmountable. Throughout the country hundreds of small firms have found ways to overcome their problems and thus gain the same advantages attained by larger industrial units through their industrial medical departments.

Industrial Medicine and Private Practice

I hope there are none who feel that industrial medical programs interfere or detract from the private practice of medicine. This point has been often discussed, but it does not apply to any program that is properly administered. Every effective occupational health program should actually enhance the practice of local physicians by making employees more aware of health.

A recent survey was made of the entire plant population at the Cleveland Works of Jones & Laughlin Steel Corporation. Approximately 3,000 workers were examined in a period of three months. One of the amazing facts disclosed by the survey was that a major portion of this group, living in a large, enlightened metropolis, had not visited a physician for periods ranging from 5 to 25 years.

Prior to this examination many of the workers had developed a purely defensive attitude toward the company medical program. Mass exposure of the plant population to its medical personnel created, and rightly so, the impression that the indivi-

dual's health is of concern to the management. Workers have learned that this is not just a selfish interest, but a real desire to raise the health standard of the entire plant group.

The part-time physician in industry, with the aid of a nurse and cooperation from all levels of management, can develop the full range of preventive medicine and conduct a health program that will more than justify its existence. It will pay for itself in dollars and cents as well as in increased productivity and rapport between management and employees. Part-time industrial physicians have much to offer management, and in return they will find occupational

health to be a stimulating and challenging diversion from private practice.

Let me close with a quotation from Dr. Will Menninger of the Menninger Foundation: "Our privilege is not only to help a man make a living, but to make a life!" Therefore, let us resolve that from our busy practices of treating illness we will take some time to practice an adequate measure of prevention. There can be no better method of doing this than becoming engaged in a program of part-time occupational health. The immediate need in this field is great and is growing rapidly each year. This gap *must* be filled, and general practitioners are qualified to do the job.

Neonatal Anemia Due to Water-Soluble Vitamin K Analogue

CASE REPORT

DONALD M. HAYES, M.D.

WINSTON-SALEM

In the last five years knowledge of the field of drug-induced hemolysis has grown rapidly. The work of Beutler and others¹ clarified the mechanism of red-cell destruction in hemolytic anemias due to certain drugs. Further study² has shown that the metabolic defect of the erythrocytes in this condition is an inherited defect. It has been shown that the hemolysis associated with primaquine, sulfonamides, fava beans³, and naphthalene⁴ is due to this inherited defect.

One group of drugs which has come under suspicion in this regard is water-soluble vitamin K analogues. The following case history is illustrative.

Case Report

A 3 week old white male, was referred to the North Carolina Baptist Hospital because of anemia and icterus. On the second day of life he had icterus and dark urine. On the third day he had bilirubinemia and a hemoglobin of "48 per cent." Although his feeding was poor for the first four to six days of life, this had improved and the icterus had lessened at the time of his referral here.

Additional history revealed that the mother had been given 10 mg. of Synkayvite (Roche Laboratories) prior to delivery. the patient received 5 mg. on the day of birth and on every other day thereafter for a total dosage of 20 mg.

Physical examination on admission showed a lethargic, moderately icteric infant, with an absence of the Moro reflex. There was no hepatosplenomegaly.

The mother, father, and patient all had type A plus blood. A Coombs' test was negative. A specimen of urine was negative for bile; urobilinogen was present in a 1:40 dilution. The serum bilirubin was 12.3 mg. per 100 ml., of which 3.6 mg. was direct-reacting. The hemoglobin was 8.0 Gm. per 100 ml.; the hematocrit 23 volumes per cent. The red blood cell count was 1,900,000, with 15 per cent reticulocytes. The white blood cell count was 11,500, with 29 per cent neutrophils, 9 per cent eosinophils, 57 per cent lymphocytes, and 4 per cent monocytes. Studies of erythrocyte carbohydrate metabolism, including reduced glutathione stability* showed only those changes

From the Department of Medicine, Bowman Gray School of Medicine of Wake Forest College and the North Carolina Baptist Hospital, Winston-Salem, N. C.

*These studies were supported in part by a grant from the North Carolina Kidney Disease Foundation.

one would expect with a substantial reticulocytosis.

The hemoglobin continued to fall to 5.0 Gm. per 100 ml. a week after admission. Transfusions raised it to 9.3 Gm. per 100 ml. Two days later it was 10.0 Gm., and the patient was discharged. When seen one month later he was well and had a hemoglobin of 10.5 Gm. per 100 ml. Although there has been no further evidence of hemolysis, the last examination showed definite evidence of central nervous system damage consistent with kernicterus.

Comment

There is no available method for definitely proving or disproving the vitamin K analogue as the cause of this patient's hemolysis. In view of the inordinately large dose he received, the absence of serologic abnormality, and the absence of evidence for other cause of hemolysis, however, this seems to be the most likely explanation.

In 1955, Allison⁵ reported a study of premature infants with kernicterus and hemolytic anemia whose only treatment had been large doses of Synkayvite. There was no evidence of incompatibility of fetal and maternal blood type⁵. Following this report he showed that large doses of water-soluble vitamin K analogues produced severe hemolysis in rats. Laurance^{6a} and Moore and Sharman^{6b} confirmed Allison's findings, recommending that the total dose of synthetic vitamin K preparation in the newborn be restricted to 2-5 mg. It has been shown that such preparations will elevate the plasma bilirubin level to a higher degree than that usually reached in untreated premature infants⁸.

The work of Zinkham⁹ showed that, while the mechanism of hemolysis in such cases may be the same as with other drugs, it does not depend on an inherited abnormality as do the other drug-related states. He believes that premature infants, because of their normal hypoglycemic state, are particularly liable to hemolysis from large doses of vitamin K analogues. Since this group of patients is also particularly liable to kernicterus, this is a condition which

must be prevented rather than diagnosed alter its occurrence.

The water-soluble vitamin K analogues should no longer be regarded as innocuous nor given promiscuously to mothers and newborns. The total dose should be restricted to 5 mg. or less, an amount sufficient to correct the defect of hemorrhagic disease of the newborn but not enough to cause hemolysis in most instances.

Summary

A case of hemolytic anemia in a newborn infant, which was of sufficient severity to cause kernicterus, is reported. The most likely cause of this state was the large dose of Synkayvite, a water-soluble vitamin K analogue, which the patient received. Following a brief review of the pertinent literature, a plea is made that the total dosage of water-soluble vitamin K analogues be restricted to less than 5 mg. in newborns.

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JUNE, 1961

THE ONE-HUNDRED AND SEVENTH ANNUAL SESSION

Although the One Hundred and Seventh Annual Session of the State Medical Society offered one of the best programs to date, the attendance of 607 members was the lowest recorded since the 444 registration in 1947, when the Society met at Virginia Beach.

There are a number of factors responsible for this poor attendance. One is that although Asheville offers excellent facilities for such a meeting, it is a long way from the center of the state, and still further from the eastern seaboard.

Another is that the meeting conflicted with the Annual Session of the American College of Physicians held in Miami Beach the same week. This conflict, together with

the fact that the Section on Internal Medicine was abandoned for this year's session, kept a number of internists from coming to Asheville and resulted in some going to Miami Beach instead.

Another factor was that the programs were mailed too late to reach more than a fraction of the members. It was unfortunate, too, that the programs of the sections that did meet—particularly the Section on General Practice—were not printed in the program booklet. The Monday and Tuesday General Sessions offered excellent discussions on subjects of wide interest: infections, differential diagnosis of abdominal pain, an interesting clinicopathologic conference, and others. The addresses by the visitors—Dr. Julian P. Price, Chairman, Board of Trustees, A.M.A.; Dr. Vincent Askey, President of the A.M.A., and Honorable Dale Alford, Congressional Representative from Arkansas—were all most interesting. Dr. Price spoke on the work of the A.M.A. Dr. Askey was the principal speaker at the President's Dinner Tuesday night and lived up to his reputation in discussing the recent attacks on the American Medical Association and the A.M.A. stand on medical care. On Wednesday morning the Honorable Dale Alford gave a magnificent address on medical legislation.

Mr. William Waddell, Duke University, President of the National S.A.M.A., gave a brief address at the Wednesday morning General Session. Many commented that his address compared favorably with that of Dr. Alford and other mature speakers.

The Memorial Service on Sunday night was impressive. Dr. Charles H. Pugh called the roll of the deceased physicians, and Mrs. William P. Richardson that of deceased Auxiliary members and wives of physicians. The Mars Hill choir gave a splendid choral presentation, and Rev. Charles D. Davis, of Mars Hill College, gave an address that was interesting, scholarly, and comforting.

The Executive Council met on Saturday. For the first time in an annual session, the House of Delegates met on Sunday, from 2:00 to 6:00 p.m. A second meeting was held on Monday afternoon, and a final, very brief session on Tuesday. One of the most important



CLAUDE B. SQUIRES, M.D.

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ant actions of the House was the decision to abandon the attempt to form a Medical Society corporation to sell Blue Cross and Blue Shield insurance—but to request the powers that be to recognize the Hospital Care Association as a Blue Shield agent.

A report of the Committee on Scientific Membership recommending that the Society maintain the position taken in 1955 was adopted. Through an unfortunate misunderstanding, the House of Delegates went on record as recommending that life members might attend all meetings of the Society but would not be eligible to vote, to hold office, or to get the NORTH CAROLINA MEDICAL JOURNAL, unless they paid dues. At the second session of the Society, a motion was adopted that this action be rescinded and that life members be eligible to vote, to hold office, and to get the NORTH CAROLINA MEDICAL JOURNAL.

Dr. George Mackie of Wake Forest was elected General Practitioner of the Year. This creates somewhat of a precedent in that Dr. Mackie has been a medical teacher as well as a practitioner. His choice was quite a popular one.

The report of the Nominating Committee apparently met with universal approval. Dr. John P. Kernodle, of Burlington, was named president-elect; Dr. John A. Payne of Sunbury, first vice president; Dr. Sam Holbrook of Statesville, second vice president; Dr. Donald Koonce of Wilmington, renamed for speaker of the House of Delegates; Dr. John C. Reece of Morganton, vice speaker of the house; Dr. John Bender of Winston-Salem and Dr. Charles R. Bugg of Raleigh, renamed for the N. C. Board of Health (four-year term).

Other nominations included Dr. John Rhodes of Raleigh, three-year term as constitution secretary; Dr. Elias Faison and Dr. Amos Johnson, delegates to the American Medical Association for two years, and Dr. C. F. Strosnider of Goldsboro and Dr. Millard Hill of Raleigh, one-year A.M.A. delegates.

The committee nominated the following district councilors:

Dr. T. P. Brinn of Hertford, Dr. Lynn

Williams of Kinston, Dr. Dewey Bridger of Bladenboro, Dr. Ed Beddingfield of Stantonsburg, Dr. Ralph Garrison of Hamlet, Dr. George Paschal of Raleigh, Dr. Ed Bivens of Albemarle, Dr. Harry Johnson of Elkin, Dr. Tom Murphy of Salisbury, and Dr. William A. Sams of Marshall.

The social highlight of the meeting was, of course, the President's Dinner on Tuesday night. Dr. Amos Johnson was given a standing ovation when Dr. Westbrook Murphy presented him with the President's Jewel. He in turn presented his wife with a gift which he said she had earned by making it possible for him to accomplish what he had done. Dr. Johnson then administered the oath of office to Dr. Claude B. Squires, who made a brief but very appropriate address in acceptance.

Russ Carlyle's Orchestra and Vaughn Monroe furnished entertainment for those at the banquet.

In spite of the poor attendance the One Hundred and Seventh Annual Session deserves to go down in history as one of the best sessions yet. Dr. Amos Johnson has made a splendid record during the past year as President and his final address was a masterpiece.

* * *

EDITORIAL NOTES

The meeting was saddened because of the absence of some familiar faces. Past President Joe Elliott died before the session began. Roscoe McMillan did not come because of the tragic death of his son in an automobile accident the week before. Dr. J. P. Rousseau of Winston-Salem was not well enough to attend. All these and others were sadly missed.

* * *

The installation of Dr. Claude Squires as President and the selection of John Kernodle as President-Elect gives assurance that our Society will continue to be in capable hands for the next two years at least.

* * *

The comments on the format of the program for this session were all favorable. The only criticisms were that they were not put in the mail soon enough and that the subjects to be discussed in the General Sessions were not given. The General Practice Section had one of the most attractive programs that any session has ever had, and it is probable that many more would have attended the meeting had they known of the treats in store for them.

Some criticism of establishing the precedent of a Sunday meeting for the House of Delegates was heard. It is true that Sunday meetings are coming to be the order of the day—but it remains to be seen whether this precedent will be continued in future years.

* * *

The Asheville profession, as before, proved to be ideal hosts. Asheville's handicap is its location—but it is to be doubted if Asheville citizens would want it changed.

* * *

ALCOHOL AND AUTOMOBILES

In this issue the experience of almost a decade with 2,315 persons suspected of drunken driving is reported in the paper by Dr. William A. Wolff, of the Bowman Gray Clinical Chemical Laboratory, and James I. Waller, Winston-Salem's Chief of Police. This report is of unusual significance, inasmuch as the chemical test for the blood level of alcohol is now becoming almost universally recognized as dependable. And, as the authors point out, "an appreciable number of persons arrested for O.A.I. were found not to be under the influence" at all, and needed to be sent to the hospital rather than to jail.

Maybe our present Legislature will recognize the wisdom of substituting scientific proof for unscientific guess work. To further this end, it is hoped that every doctor who reads Dr. Wolff's paper will tell his representative about its contents.

* * *

THE BACTERIOLOGIST SHOULD RETURN TO THE WARDS

An editorial in the *Canadian Medical Association Journal* for March 4 is so timely that most of it is reproduced below.

* * *

Through the fault of no one in particular, the bacteriologist has of recent years, in his modest and retiring way, become ensconced in his laboratory, there to commune in solitude with his numerous specimens. As a result he has tended to become more and more

purely a technician, not using his total medical knowledge . . .

The bacteriologist should return to the wards where his advice is badly needed. Antibiotics are no longer the universal panacea they were once thought to be. Many have been used too readily and without due consideration of consequences. To counter this undesirable state of affairs it is essential that the knowledge of the bacteriologist in regard to antibiotic resistance to drugs be released from its seclusion in the laboratory and brought to the bedside of the patient, in consultation with the other physicians and surgeons concerned with the details of patient-care.

Such direct participation of the bacteriologist in the deliberations of the treatment team is being provided in other parts of the world, as Ericsson, of the Department of Bacteriology in the Karolinska Institute Sjukhuset, Stockholm, points out in a recent monograph.

At the Karolinska Hospital a number of basic principles have been established for the use of antibiotics. The first obvious need is that the bacterial etiology of the disease being treated, and the sensitivity to antibiotics of the organism involved, be established. The decision to use the antibiotic of choice is reached after due and careful consideration of the general condition of the patient and the probable prognosis of his disease. When an antibiotic is used, dosage levels should be high in order that the drug may exert its maximum effect. Subtherapeutic doses of antibiotics should be uniformly avoided, except when they are to be used as a prophylactic measure in special situations, as in the case of patients with previous rheumatic fever, osteomyelitis or bacterial endocarditis. In most situations low dosages favour the development of resistant strains of organisms, quite clearly an unsatisfactory situation.

With a return of the bacteriologist to the wards, his critical approach could greatly assist in the more effective use of antibiotics.

Bulletin Board

COMING MEETINGS

North Carolina State Board of Medical Examiners — Hotel Sir Walter, June 19-22.

Duke Medical Postgraduate Course — Morehead-Biltmore Hotel, Morehead City, July 17-22.

Southern Obstetric and Gynecologic Seminar — Grove Park Inn, Asheville, July 17-22.

Tri-State Medical Association of Virginia and the Carolinas, Annual Meeting — Cavalier Hotel, Virginia Beach, Virginia, July 27-28

American Medical Association, Annual Meeting — New York City, June 26-30.

American Physicians Art Association, Twenty-fourth Annual Exhibition — New York City, June 26-30.

Rocky Mountain Cancer Conference — Brown Palace West, Denver, Colorado, July 12-13.

NEW MEMBERS OF THE STATE SOCIETY

The following new physicians joined the Medical Society of the State of North Carolina during the month of April. Dr. Charles Phillip Ford, Jr., E. I. duPont de Nemours and Co., Kinston; Dr. James Grady Jones, 3421 Hagaru Drive, Tarawa Terrace; Dr. Franklin Delane White, 543 Williams Street, Jacksonville; Dr. Benjamin Everett Thompson, Jr., 124 S. Academy Street, Cary; Dr. Paul Fleming, 628 Woodburn Road, Raleigh; Dr. Floyd Wolfe Denny, Jr., University of North Carolina School of Medicine, Chapel Hill; Dr. Lester Leigh Smith, Jr., 1350 Kings Drive, Charlotte;

Dr. Ernest Gustave Newman, Jr., 2614 Charlotte Street, Durham; Dr. James Chester Brewer, Jr., 604 Dogwood Lane, Guilford College; Dr. Vincent Lawrence DiRienzo, 230 E. Franklin Street, Rockingham; Dr. Lamuel Edgar Barnhill, Jr., 401 Carolina Drive, Murfreesboro; Dr. Jimmie Dale Simmons, 819 Rockford Street, Mount Airy; Dr. Hal Martin Stuart, 111 E. Main Street, Elkin; Dr. Martin John Kreshon, 106 W. 7th Street, Charlotte.

NEWS NOTES FROM THE UNIVERSITY OF NORTH CAROLINA SCHOOL OF MEDICINE

Distinguished service awards were presented April 14 to five former students of the University of North Carolina School of Medicine as the climax to the annual Alumni Day.

The awards went to Dr. H. McLeod Riggins, New York, native of Matthews and a specialist in internal medicine and diseases of the chest; Dr. J. W. R. Norton, Raleigh, state health director and career official in the public health field; Dr. Ben E. Washburn, Rutherfordton, public health official who has served on the staff of

the Rockefeller foundation in North Carolina, the West Indies, Central and South America; Dr. James H. Wall, White Plains, New York, a South Carolina native and professor of clinical psychiatry at Cornell University; Rear Admiral Allan S. Chrisman, U. S. Navy, Washington, a native of Greensboro and currently surgeon general and assistant chief of the Bureau of Medicine and Surgery of the Navy Department.

Chancellor William B. Aycock of the University spoke on "The Medical School in the University," and Dr. Berryhill gave a report on some policies and progress in the Medical School.

Dr. Hugh A. McAllister of Lumberton was installed as president of the Medical Alumni Association, succeeding Dr. John S. Rhodes of Raleigh.

New officers elected were: Dr. Harry Brockmann, High Point, president-elect; Dr. A. L. Daughtridge, Rocky Mount, vice president; Drs. G. T. Wood, High Point, and S. M. Beale, Elkin, elected to the board of counselors.

A portrait of Dr. Daniel A. MacPherson was presented to the School of Medicine in a special ceremony Friday afternoon. Dr. MacPherson has been on the medical school faculty for 38 years.

Scientific sessions were held during the morning and after the luncheon meeting. Dr. Floyd Denny, new head of the Department of Pediatrics, spoke on "Pediatrics—Its Promise and Its Future." This was followed by a panel discussion on "The Hospital, the Physician and the University".

Special activities were planned for alumni wives including a luncheon and program on flower arrangement.

The following physicians from the University of North Carolina School of Medicine participated in the annual meeting of the South Carolina Medical Association at Charleston on Thursday, April 27: Dr. James F. Newsome, assistant professor of surgery; Herbert S. Harned, assistant professor of pediatrics; Dr. William B. Blythe, instructor in medicine; Dr. A. Stark Wolkoff, assistant professor of obstetrics and gynecology; and Dr. Charles A. Bream, associate professor of radiology.

Dr. Charles W. Tillett, director of the Visual Aids Clinic, was a participant in the 1961 Sight Saving Conference of the National Society for the Prevention of Blindness held in Chapel Hill recently. Dr. Tillett was a member of a panel which discussed "The Value of Low Vision Aids."

* * *

The fifth annual Parents' Day was held at the School of Medicine Saturday, April 22.

The annual general meeting of the U.N.C. Medical Parents' Club was presided over by Dr. Carey H. Bostian, Raleigh, president of the organization.

Parents and visitors to the annual program were welcomed by Dr. Reece Berryhill, Dean.

A number of medical students took part in the morning program. The following officers were elected: president, Harry L. Riddle, Sr., Morganton; first vice president, H. L. Pitser, Raleigh; second vice president, C. C. Dudley, Huntersville; secretary, Zebulon Weaver, Asheville.

Regional meetings of parents followed the annual business meeting of the Club. Tours of the hospital and Medical School were held prior to the morning general meeting, and during the afternoon hours following lunch. Box lunches were served on the grounds in rear of the hospital to over 300 persons.

A feature of the annual meeting was the surprise presentation of a Certificate of Appreciation to Dr. Berryhill for the able leadership which he has provided the Medical School and North Carolina Memorial Hospital.

* * *

The donors of the books were Dr. Warner Wells, U.N.C. associate professor of surgery; and Dr. W. G. Smillie, author of a number of books in the fields of public health and preventive medicine.

The book given by Dr. Wells is "Guydos Questions" by Guy of Chauliac. It was printed in London by Thomas East in 1579.

The book donated by Dr. Smillie is generally known as "the most remarkable document in the history of public health." It is a copy of "Report of a General Plan for the Promotion of Public and Personal Health" by Lemuel Shattuck. The book was published by the State of Massachusetts in 1850.

* * *

Five members of the faculty of the Department of Obstetrics and Gynecology participated in the annual meeting of the American College of Obstetricians and Gynecologists at Miami Beach, Florida, April 23-28. They are Dr. Leonard Palumbo, Dr. Jack Mohr, Dr. Stark Wolkoff, Dr. James Donnelly, and Dr. Robert A. Ross, head of the Department of Obstetrics and Gynecology.

* * *

The Section of Physical Therapy of the School of Medicine presented as guest speaker on April 28 Miss Dorothy Page, director of Center Services at the Albany Hospital Cerebral Palsy Center at Albany, New York. She spoke on "Modern Concepts in the Treatment of Cerebral Palsy."

NEWS NOTES FROM THE DUKE UNIVERSITY MEDICAL CENTER

Dr. Kenneth L. Pickrell, professor of plastic surgery at the Duke University Medical Center, was honored in Asheville on May 10 for outstanding service on behalf of the physically handicapped in North Carolina.

He received citations from President Kennedy's Committee on Employment of the Physically Handicapped and from the North Caro-

lina Commission on Employment of the Physically Handicapped as North Carolina's Physician of the Year.

* * *

Conrad M. Knight has been appointed to the newly established position of radiological safety officer at Duke University.

Formerly employed at the Atomic Energy Commission in Washington, D. C., he is responsible for the coordination and supervision of radiation safety procedures at the University.

* * *

Dr. Philip Handler of the Department of Biochemistry, Duke University Medical Center, has been elected president of the American Society of Biological Chemists for 1962-1963. He will serve as president-elect during the coming year.

* * *

Dr. Kenneth S. McCarty of the Department of Biochemistry, Duke University Medical Center, addressed the Federation of American Societies of Experimental Biology in Atlantic City last month. Dr. McCarty described research which suggests that changes in the enzymatic constitution of body cells may be the first step in transforming cells from normal to malignant.

* * *

At the same meeting Dr. Donald B. Hackel, professor of pathology at Duke, was honored by the American Society for Experimental Pathology, one of six member organizations of the Federation. Dr. Hackel received this year's Experimental Pathology Award given in recognition of outstanding research by a pathologist under 40 years of age. The 39 years old Duke Scientist was chosen on the basis of his contributions to fundamental knowledge of heart and kidney disease. The award carries a \$1,000 honorarium contributed by Parke, Davis and Company.

* * *

Dr. Eugene A. Stead, Jr., chairman of the Duke Medical Center's Department of Medicine, was elected secretary of the Association of American Physicians during the Association's annual meeting in Atlantic City recently. He will serve for a one-year term.

Dr. James B. Wyngaarden, professor of medicine at Duke, was elected a member of the Association during the Atlantic City meeting.

* * *

Dr. J. E. Markee, James B. Duke Professor of Anatomy and departmental chairman at the Duke University Medical Center, has been chosen chairman-elect of the Council on Medical Television.

Organized to bring together persons concerned with the use of television for medical teaching, the Council includes representatives of the American Medical Association, Association of American Medical Colleges, American Academy of General Practice, American College of Sur-

geons, medical schools, television manufacturing concerns, philanthropic organizations, and other groups.

* * *

Dr. Lloyd J. Borstelmann, faculty member in the psychiatry and psychology departments at Duke and chief psychologist at the Durham Child Guidance Clinic, spoke on "Parent Education for Child Mental Health" at the annual meeting of the Southeastern Psychological Association held in Gatlinburg, Tennessee, in April.

* * *

Dr. Nicholas G. Georgiade, associate professor of plastic, maxillofacial and oral surgery at Duke, has been chosen to head the American Society of Maxillofacial Surgeons during 1962-1963. He will move from the vice presidency to the presidency a year from now. At that time he will succeed Dr. Orion Stuteville of the University of Illinois as president.

* * *

Dr. Norman F. Ross, head of the Duke University Medical Center's dentistry division, assumed the presidency of the North Carolina Dental Society on May 17 during the organization's annual meeting in Pinehurst.

NEWS NOTES FROM THE BOWMAN GRAY SCHOOL OF MEDICINE OF WAKE FOREST COLLEGE

Dr. Cornelius F. Strittmatter has been appointed Odus M. Mull Professor of Biochemistry and chairman of the department of biochemistry at the Bowman Gray School of Medicine.

The appointment, announced recently by Dean C. C. Carpenter, is effective August 15, 1961.

Dr. Strittmatter, 34, has been associated with the research and teaching programs of the department of biological chemistry at Harvard Medical School since 1952. He is currently an assistant professor.

He took a bachelor's degree in biology and chemistry from Juniata College, and obtained a Ph.D. degree from Harvard Medical School, where his thesis work on mammalian cytochrome components was carried out under Dr. Eric G. Ball.

He is now a Senior Research Fellow of the U. S. Public Health Service and a consultant in biochemistry to the pathology department of New England Deaconess Hospital.

He will succeed Dr. Camillo Artom as chairman of the biochemistry department at Bowman Gray School of Medicine. Dr. Artom will continue to serve on the medical school faculty as a professor of biochemistry.

* * *

New faculty appointments and promotions, effective July 1, 1961, were announced recently by Dr. C. C. Carpenter, dean of the medical school.

The new appointments are: Dr. Gordon K. Mid-

dleton, instructor in pediatrics; Dr. Thomas F. O'Brien, instructor in medicine; Dr. John M. Pixley, instructor in psychiatry; Mr. Richard L. Witcofski, instructor in medical physics; Dr. Paul F. Williams, instructor in preventive medicine; Dr. Mary Ann Hampton, assistant in preventive medicine; and Dr. Donald C. Hartzog, assistant in clinical medicine.

New promotions are: Dr. James F. Martin, from associate professor to professor of radiology; Dr. Robert W. Prichard, from associate professor to professor of pathology; Dr. Hugh B. Lofland, from assistant professor to associate professor of biochemistry; Dr. Damon D. Blake, from instructor to assistant professor of radiology; Dr. A. Robert Cordell, from instructor to assistant professor of surgery; Dr. Donald M. Hayes, from instructor to assistant professor of medicine; Dr. Richard G. Kessel, from instructor to assistant professor of anatomy; Dr. J. Stanton King, from instructor to research assistant professor of biochemistry; Dr. Malcolm B. McCoy, from instructor to assistant professor of audiology; Dr. Jesse H. Meredith, from instructor to assistant professor of surgery; Dr. Benjamin F. Huntley, from assistant to instructor in clinical medicine; Dr. John H. Nicholson, from assistant to instructor in clinical medicine; Dr. William C. Sugg, from assistant to instructor in clinical medicine.

* * *

For the fourth consecutive year, the Z. Smith Reynolds Foundation awarded \$150,000 in scholarships to eight students who have been accepted for admission to the Bowman Gray School of Medicine. An awards banquet was held April 21, 1961, in Winston-Salem.

The scholarships provide for the total cost of the four years of medical school and for two years of hospital or postgraduate training. Four of the scholarships provide stipends totaling \$23,400. The others provide stipends totaling \$14,400.

The Reynolds Scholars, all from North Carolina, were selected by the medical school committee on admissions on the basis of character, scholarship, potential as a physician and financial need.

* * *

More than 120 alumni and faculty of the Bowman Gray School of Medicine attended a luncheon, May 9, at Asheville's Battery Park Hotel. The luncheon, held in association with the North Carolina Medical Society's annual meeting, was sponsored by the Bowman Gray School of Medicine Medical Alumni Association. Dr. George Paschal Jr. of Raleigh presided.

* * *

Several members of the Bowman Gray School of Medicine faculty and staff presented papers at meetings of the Federation of American Societies for Experimental Biology, April 10-15, at Atlantic City, N. J. They are Dr. Harold D. Green, Gordon

Gray Professor of Physiology and Pharmacology; Dr. J. Maxwell Little, professor of pharmacology; Dr. Thomas B. Clarkson, associate professor of experimental medicine; Dr. J. Richard R. Bobb, associate professor of physiology and pharmacology; Dr. Carlos E. Rapela, associate professor of physiology and pharmacology; Dr. Herman E. Schmid, instructor in physiology and pharmacology; and Drs. Haruka Okina and Carmelo Nepomuceno, trainees in the cardiovascular graduate training program.

* * *

Dr. Martin G. Netsky, professor of neurology and neuropathology, served as Visiting Professor of Neurology to Louisiana State University School of Medicine at New Orleans in late March. During his visit to New Orleans, he also was an assistant examiner for the American Board of Neurology and Psychiatry.

* * *

Dr. Richard Proctor, associate professor and chairman of the Department of Psychiatry, has been elected president of the Southeastern Psychiatric Society.

* * *

Dr. Merrill P. Spencer, associate professor of physiology and pharmacology, has been appointed to a four-year term on the Cardiovascular Study Section of the National Heart Institute.

NORTH CAROLINA STATE BOARD OF MEDICAL EXAMINERS

The Board of Medical Examiners will meet at the Sir Walter Hotel, Raleigh, June 19-22, at which time the written examination will be held.

Candidates for licensure by endorsement of credentials will be interviewed June 20.

AMERICAN BOARD OF OBSTETRICS AND GYNECOLOGY

The following North Carolina physicians were recently examined and certified in the specialty of obstetrics and gynecology:

Drs. Maurice Shehadeh Berbary, MC, Womack Army Hospital, Fort Bragg; Ben Robert Boyett, Jr., Goldsboro; Clifford Conwell Byrum, Raleigh; Maurice G. Couturier, Sr., Reidsville; Posey E. Downs, Jr., Charlotte; Amzi Jefferson Ellington, Burlington; Raymond Curtis Houghton, New Bern; Clayton J. Jones, Concord; Talbot Fort Parker, Jr., Goldsboro; Rufus T. Rankin, Jr., Charlotte; Charles L. Saunders, Jr., Burlington; Bessie Kay Williams, High Point.

EDGECOMBE-NASH MEDICAL SOCIETY

The regular monthly meeting of the Edgecombe-Nash County Medical Society was held at the Rio Restaurant on Wednesday, May 10. Delegates to the state medical society reported on the annual meeting in Asheville.

EMORY UNIVERSITY SCHOOL OF MEDICINE

Emory University has received \$250,000 to establish a chair of preventive medicine and community health in its medical school.

The gift came from the estate of the late Mrs. Amelie McAlister Upshur who left the bequest as a memorial to her father, William H. McAlister. The post the gift endows will be known as the McAlister Chair of Preventive Medicine and Community Health.

Last year Dr. Thomas F. Sellers Jr. became chairman of the department. A graduate of the Emory medical school in 1950, Dr. Sellers is the son of Emory alumnus Dr. T. F. Sellers Sr., veteran of 18 years public health service work in Georgia. Dr. Sellers, Sr., retired last year, now serves in his son's department as volunteer clinical professor of preventive medicine and community health.

AMERICAN CANCER SOCIETY

"The physician and the Total Care of the Cancer Patient" is the topic of the 1961 Scientific Session to be held in conjunction with the American Cancer Society's annual meeting, October 23-24, in New York City.

For further information write: Professional Education Section, American Cancer Society, 521 West 57 Street, New York 19.

AMERICAN PHYSICIANS ART ASSOCIATION

The twenty fourth annual exhibition of the American Physicians Art Association will be held from June 26 to 30 in New York City in conjunction with the annual meeting of the American Medical Association. The exhibit will include works of sculpture, painting, crafts, and photography by physicians throughout the United States.

Further information can be obtained from Dr. Alfred A. Richman, secretary, 307 Second Avenue, New York 3, New York.

ROCKY MOUNTAIN CANCER CONFERENCE

The fifteenth annual Rocky Mountain Cancer Conference will be held at Denver's completely air-conditioned Brown Palace West, July 12-13, and will feature panel discussions on "Detect Cancer in Time!—Procedures, Problems and Solutions," and "Neoplasms of the Female Genital Tract."

Presidents of both the American Cancer Society and the American Medical Association will participate in the two-day program. Application has been made for A.A.G.P. accreditation for the Conference.

Further information may be obtained by writing Rocky Mountain Cancer Conference, S35 Republic Building, Denver 2, Colorado.

WORLD MEDICAL ASSOCIATION

Dr. Harry S. Gear, an eminent international medical leader in the field of hygiene and tropical medicine, will become Secretary General of The World Medical Association on July 1, 1961. Dr. Gear is currently the Director of Pneumococcal Research, Council for Scientific and Industrial Research—Industrial Medicine in Johannesburg, South Africa.

DEPARTMENT OF THE ARMY

Colonel George R. Carpenter, Chief of the Preventive Medicine Division of the First U. S. Army Medical Section, retired at Governors Island on April 30 after more than 20 years active service with the Army.

He was formerly Public Health physician in Wilmington, North Carolina, and in Fairfax and Bristol-Washington Counties in Virginia. He was graduated from the University of Virginia School of Medicine in 1934 and earned the Master of Public Health degree at Johns Hopkins Hospital School of Hygiene and Public Health in 1939.

Merrell Produces Film on Chemical Tests for Intoxication

Alcohol is involved in half of all traffic accidents which result in injury or death, but there is hope for greater highway safety through scientific tests for drunkenness which are acceptable in court.

This fact is brought out as experts from the fields of medicine and the law discuss the problem of the drinking driver in a new motion picture, "The Silent Witness," shown recently in Cincinnati.

The film was produced by The Wm. S. Merrell Company (Davidson of Richardson-Merrell Inc.) in cooperation with the American Medical Association and the American Bar Association. It deals with the chemical tests for intoxication

and is the sixth in a series of Merrell-American Medical Association films on medicolegal subjects.

"The Silent Witness" brings questions and answers about alcoholism tests into the open through the story of a drinking driver who is arrested, tested by the police, and tried. It is described as "a motion picture of importance to those who drink, those who drive, and those who judge their fellow men."

Prints are available for showing before interested groups. Contact the American Medical Association's Film Library, Chicago, or The Wm. S. Merrell Company, Division of Richardson-Merrell Inc., Cincinnati 15, Ohio.

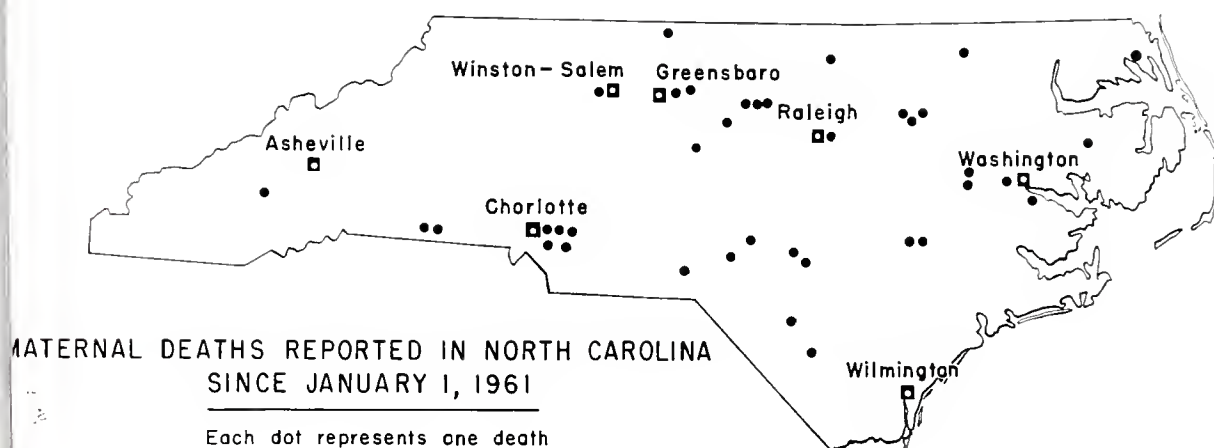
Surgical Hospitals Expected to Replace Pediatric Hospitals

Surgical hospitals for children under 15 years of age may replace pediatric hospitals during the next 20 years, a Dallas hospital administrator predicted recently.

A sharp rise in the number of children entering hospitals for surgical reasons is expected, along with a sharp drop in the number entering for general medical reasons, Roderic M. Bell of Presbyterian Hospital said in **Hospitals**, journal of the American Hospital Association.

Among the reasons Mr. Bell listed for the expected change are that antibiotics have made possible outpatient and home care of many acute ills, and that other diseases, such as rheumatic fever, appear to have become milder. He said many children who might previously have died now survive, but with handicaps which can be corrected surgically.

The rooming-in system is "one of the most significant changes for future pediatric planning," according to Avery C. Faulkner, of Faulkner, Kingsbury and Stenhouse, Architects, Washington, D. C., and consultant to the Surgeon General of the Army.



Book Reviews

Blood Diseases of Infancy and Childhood by Carl H. Smith, M.D. 572 pages. Price, \$17.00. St. Louis: The C. V. Mosby Company, 1960.

There has long existed a need for a complete text in pediatric hematology written by a pediatrician. This need has been well filled by the comprehensive text written by Dr. Carl Smith, a pediatrician and hematologist.

The author presents the basic physiopathologic processes involved in a clear manner, and correlates these processes with specific diseases seen in ordinary practice. There are also a large number of practical comments, obviously gleaned from years of practicing and teaching pediatric hematology. Those who do not have time for a complete review of a particular problem will find the numerous outlines and tables helpful. Each of the 27 chapters is followed by a comprehensive bibliography for those who wish to pursue a particular subject further.

The general practitioner of pediatrics will appreciate the chapters on transfusions in pediatric practice, jaundice, erythroblastosis fetalis, iron deficiency anemia, and infectious mononucleosis. Those interested in some of the newer concepts and avenues of research will find up-to-date chapters on the hemoglobinopathies and the erythrocyte enzyme deficiencies related to some of the hemolytic anemias. The inclusion of a chapter on the disorders of the spleen and reticuloendothelial system (Gaucher's Disease, Nieman-Pick's Disease, Letterer-Siwe Disease, etc.), is further evidence of the complete coverage of hematology and closely related subjects.

Perhaps the most outstanding chapter in enabling the reader to grasp the essentials of a complex subject is that dealing with coagulation. The author discusses this rapidly changing topic in an unusually clear manner. The chapters on purpura and leukemia are adequate.

This text fills a gap which has existed in pediatric literature for some time. Any physician dealing with infants and children will find it invaluable.

Thinking and Psychotherapy: An Inquiry into the Processes of Communication. By Harley C. Shands, M.D., with a Foreword by Stanley Cobb, M.D. 319 pages. Price, \$5.75. Cambridge, Massachusetts: Harvard University Press, 1960.

This work represents an extremely scholarly synthesis of knowledge from many fields—philosophy, psychology, sociology, anthropology, physiology, physics, mathematics, ethnology, psychiatry, and psychoanalysis—with the object of bringing us to a closer and clearer understanding

of the psychoanalytic method and its relation to communicative therapy. It carries to its logical conclusion the premise that psychology differs from physiology only in degree of complexity and not in content. As Dr. Cobb states, "If good synthesis is philosophy, here is a philosophy of psychology in its broadest sense—and the author . . . deserves the title of philosopher."

Dr. Shands has divided his book in two sections. In the first he propounds a "Physiological Theory of Communication." In the second he puts forth the "Implications for Psychotherapy." He defines psychotherapy in terms of a dynamic relationship based on a "dyad"—two minds in interaction—rigidly structured in the strict method of free association, and analysis and resolution of the transference, as first formally established by Sigmund Freud and employed, with some slight modifications, by his adherents. He feels that the method is a much greater contribution to science than is the theory promulgated by Freud or any of the many modifications of psychoanalytic theory formulated by his followers. The method is more valuable as a scientific tool for understanding human function than as a means of therapy.

In the first part of the book, Dr. Shands points up the continuity from the physiological aspects of thinking (internalized communication), through the linguistic code of the social system, to its potential application in psychology and psychiatry. He takes up in detail the basic instruments: the "nervous system"—the internal instrument, and "language"—the external instrument. He then discusses thinking as a mechanism of adaptation and as a skill and some general features of skilled action. Finally he devotes a chapter each to (1) "The necessary condition for thinking: an intact nervous system"; (2) "The sufficient condition for thinking: a social system"; and (3) "The creative condition for thinking: an ability to synthesize patterns."

Dr. Shands point out a way in which continuity across related but apparently disparate fields can be demonstrated. He is concerned with putting statements in a way that will be subject to precise observational verification or falsification. He attempts to point up the importance of the "deviant" in human relations, which may lead to further investigation. He emphasizes the importance of relativity in the field of thinking, communication and behavior, as well as in physics. Further, he acknowledges his debt to Piaget in his development of the evaluation of "reflective thinking" and how this can be studied in the psychotherapeutic relationship.

In the second part, Dr. Shands discusses the way psychotherapy fits into the prevailing currents of twentieth century thought. There is more concern with the nature of thought than with the content. He points up the goals of psychotherapy—that is, to lead the individual to see

himself from the point of view of another and to achieve thereby a greater adaptability, a more creative and satisfactory adjustment. Finally he discusses some of the defense mechanisms in terms of neurophysiological function as "distancing mechanisms," and divides them into three classes: alteration of point of view, diminution of informational input, and stereotypy of output.

This philosophical treatise is not intended or claimed to be the final synthesis in the field of thinking and psychotherapy, but it does serve as a scholarly formulation from which the author and others can pursue the search toward the truth.

A Synopsis of Contemporary Psychiatry.

By George A. Ulett, Ph.D., M.D., and D. Wells Goodrich, M.D. Ed. 2. 309 pages. Price, \$6.50. St. Louis: The C. V. Mosby Company, 1960.

The second edition of this little book is as complete and thorough as such a synopsis can be. It should be helpful to the student for quick orientation and review, and especially valuable to the general physician in practice. This reviewer would like to recommend one addition to the psychiatric team—a qualified chaplain or pastoral counselor. Experience has shown that such a person can be an invaluable addition to the psychiatric team.

Physical Disability — A Psychological Approach. By Beatrice A. Wright, Ph.D. 408 pages. Price, \$6.00. New York: Harper Brothers, 1961.

Although designed as a combination text and case book for students and practitioners in the field of rehabilitation, this book merits the attention of any doctor who deals with physically deviant persons. Indeed the author concludes, on the basis of her own clinical experience and the investigations of others, that the problems of the physically disabled are essentially the problems of "normal" individuals—deprivation, loss (the reaction to sudden physical impairment is compared with mourning after bereavement), the threat of social isolation, the struggle for independence and status, acceptance of a limitation, and so forth.

The first part of the book defines and analyzes the problem, not on the basis of separate categories such as blindness or crippling, but with regard to the situations met by disabled persons of all types and age groups. The sociologic aspects of disability as well as the somatopsychologic factors are carefully scrutinized. Among the topics considered are status position, development of the self concept, grievances and gratifications in everyday relationships, value changes

in acceptance of disability, and sources of attitudes toward atypical persons.

Mechanisms for dealing with the challenge of disability are then discussed. Throughout this and other parts of the book, emphasis is placed on the "coping" as opposed to the "succumbing" attitudes, a concept of considerable importance to the doctor dealing closely with disabled persons and their families. Because of this close relationship during the early phases of a crippling disease or injury, the doctor's own attitudes, conscious or unconscious, exert an influence for better or worse.

The final chapter, "An Assessment of Somatopsychology," reviews the work of Sheldon and others concerning the relation of physique to personality. While findings in this field are inconclusive and point up the need for further investigation, there appears to be no substantial indication that persons with impaired physique differ as a group—though they differ widely within the group—in their over-all adjustment. It is the interplay of events inside the person with events from without that affects his efforts to manage himself "more wisely, comfortably, and happily."

Dr. Wright's approach is at all times scientific and yet unfailingly human. Theoretical concepts are documented with concrete examples drawn from the literature, from autobiographical writings of the disabled themselves, and from numerous case histories.

The book can be read with interest and profit by physicians in many areas of practice; to those with a special interest in rehabilitation it should prove invaluable.

Fundamentals of Psychology: The Psychology of Thinking. Edited by Ernest Harms and Franklin N. Furness. *Annals of the New York Academy of Science.* Vol 91, Art. 1, pp. 1-158.

The contributors to this monograph were selected from among recent writers on the psychology of thinking. Presented are what appear to be the major problems occupying present day psychologists in the field of the psychology of the thought processes. Adherence to any specific school of psychology has been avoided in the hope of gaining wider constructive concepts for further development.

A natural choice for conference chairman lay in the selection of J. P. Guilford, past president of the American Psychological Association, who for some years has addressed his research efforts to creativity and related functions. Each of the other authors is eminent in his own right, and some are equally well known.

Of all the puzzling problems that have fallen to the lot of psychologists, those relating to human thinking have been the most frustrating.

The history of psychology reveals a number of futile efforts to reach a significant and useful comprehension of thinking. Men are confronted with the fact that most thinking is well beyond direct observation.

In a different approach, Guilford attempts to answer the question of what thinking operations exist. He ignores the classic stimulus-response model and turns to a factor-analytic approach which examines covariation and capitalizes on a multivariate experimental design adaptable to the complexity of the phenomenon. A three dimensional model for the structure of intellect is presented.

Brunec addresses himself to three aspects or problems in the study of thinking, and to the structure of language. With regard to memory he writes that "the real problem is organization, for it is organization that makes information available when needed."

Kurt Goldstein has been recognized for many years for his research on abstract and concrete thought processes. In writing here on thinking and speaking, he says that "both are instigated by the different occurrences in the organism in its attempt to come to terms with the outer and inner world, although thinking in its symbolic form plays the dominant and regulative role. Words are apparently not tools that may be

handled like objects, but are means to help man to organize the world in a particular, conceptual and symbolic way."

Kendler, in writing of learning, development and thinking, described experiments which disclosed that about half of the 6 year old children studied were conceptualizing, and he observed that this age corresponds with that at which many nations begin the education of their children.

Johnson, in a serial analysis of thinking, reports experiments to analyze problem-solving sequentially, and to attempt to describe the whole problem-solving enterprise in terms of sequential thought processes.

In discussing "Relations between motivational conditions and thinking," Vinacke attempts to explain the organization of "consciousness," or the relation between environment and the ongoing behavior of the individual. He regards thinking as the utilization of past experience in response to motivational states. He uses the term "motivation" to refer to the inferred processes that instigate, regulate, and adjust behavior.

Cofer discusses "Experimental studies of the role of verbal processes in concept formation and problem-solving."

Taylor believes that creative thinking, decision-making, and problem-solving all fall with-

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to the brain
in the
"senility syndrome"
associated
with
cerebrovascular
insufficiency



in the general area of thinking. He defines creativity as that thinking which results in the production of ideas or other products that are both novel and worth while.

According to Luchin, who discusses the creativity problem in thinking, contemporary research on creativity is concerned mainly with studying creative individuals. Research is also needed on a somewhat neglected aspect of the problem—namely, how to characterize and study creative acts rather than actors; for example, how to investigate the act independently of the personality of the individual who performs the act.

Hematopoiesis: Cell Production and Its Regulation. Ciba Foundation Symposium. Edited by G. E. W. Wolstenholme and Maeve O'Connor. 490 pages. Price, \$11.00 Boston: Little, Brown and Company, 1960.

This book is a reproduction of the proceedings of an international symposium sponsored by the Ciba Foundation in February, 1960. The participants are all recognized authorities in the fields of hematology, cell biology, and radiobiology. The majority are from the United States, Great Britain, and Canada.

There is a wealth of material concerning the

production, control, life span, and destruction of all cells originating in the hematopoietic system. The most intriguing part of this material is that having to do with red-cell production and its humoral regulation by one or more substances known as erythropoietin. Since most of the present medical generation studied red-cell production as a simple "supply and demand" system, governed for the most part by arterial oxygen tensions, this section of the proceedings carries much that is new and different in this field. Discussion by such authorities as A. S. Gordon, L. O. Jacobson and L. G. Lajtha gives an authoritative air to these sections.

In regard to the other cellular elements of the blood, much of the information is less definite but equally stimulating. The work of C. G. Craddock relating to the production and distribution of granulocytes and the concept of the "granulocyte pool" has been presented more completely in other sources, but remains of interest.

For one interested in further areas of exploration regarding cell production, leukemia, and the metabolically determined anemias such as pernicious anemia, the discussions included are the real meat of this book. Reading these discussions by outstanding authorities gives one some idea as to what the future holds in these areas, what

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references: 1. Madow, L.: *Penn. M. J.* 62:861, June 1959. 2. Stieglitz, E. J.: *Geriatric Medicine*, ed. 2, Philadelphia, Saunders, 1949 p. 274. 3. Winsor, T., et al.: *Amer. J. Med. Sciences* 239:5 May 1960. 4. Eisenberg, S.: *ibid*, July 1960.

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tools and methods will be used, and what the limitations of these methods are. If one is intimately connected with these fields, it is very possible that he may obtain new ideas for further needed research.

As most of the Ciba symposia, this book makes no pretence at being anything other than a highly scientific, highly specialized collection of information. The book would be of great value to medical students, house officers and researchers who are interested in these particular fields. For the practicing physician who immediately is not particularly interested in these fields, the book offers little that is applicable to patient problems.

W. B. SAUNDERS COMPANY features the following recent books in their full page advertisement appearing elsewhere in this issue:

WHITE—CLINICAL DISTURBANCE OF RENAL FUNCTION

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In Memoriam

James Wilson Gibson, M.D., F. A. C. S.

August 6, 1894 - November 11, 1960

The Mecklenburg County Medical Society laments the passing of one of its most prominent and popular members in the untimely death of Dr. James Wilson Gibson, on November 11, 1960, caused by a fall from his horse.

Dr. Gibson was the fifth in a line of distinguished physicians and surgeons. His great, great grandfather, Dr. John Hannon Gibson, came from England to Philadelphia, having been educated at Edinborough, Scotland. His great grandfather, Dr. John Hayshem Gibson, came from Philadelphia to Charlotte, as assayer of the U. S. Mint, a considerable amount of gold being mined in Mecklenburg County at that time. His grandfather, Dr. Robert Gibson, practiced medicine in Charlotte and served as a surgeon in the confederate army. His father, Dr. Robert Lardner Gibson, who died in 1953, was a widely known and loved surgeon of this city for many years.

Dr. James Gibson was ably endowed by nature to be a good doctor. He had a strong constitution physically, a bright mind, a friendly personality, a marvelous wit, and a real interest in people. He had good surgical training and a wonderful apprenticeship with his father, from whom he learned much of the art of medicine and sound surgical judgment, essential characteristics of a real surgeon. A treatment to this fact was not

only the number of physicians who sought him as a consultant, but the number of physicians who had him as their surgeon.

Dr. Gibson took a great personal interest in his patients. He made it a point not to stand, but to sit in a chair by the bed at some time during the patient's convalescence and give him time to ask questions that came to mind.

Dr. Gibson received his primary education at a private school at Presbyterian College, then located at the site of Queens College today. He attended Woodberry Forest at the age of 15. After a year there, he entered Davidson College, where he received his A.B. degree in 1914. He was graduated from Jefferson Medical College in 1918, following which he was intern and resident for two years at Pennsylvania Hospital at 8th and Spruce Streets, Philadelphia.

In 1920, he went into the practice of surgery with his father in this city.

In 1923 he married Catherine Ottley Gilmer of Charlotte. They have three children: Catherine (Mrs. Kenneth Tanner of Rutherfordton), Mary (Mrs. John Hallett of Fort Mill, South Carolina), and Robert Lardner Gibson, II, of Charlotte. There are five grandchildren. He is survived by his wife, children, grandchildren, and four sisters.

Dr. Gibson wasted little time while on this earth. Idleness was unknown to him. He was an extensive reader. He has published at least 27 articles in medical literature. These articles deal not only with abdominal surgery, but with plastic surgery, neurosurgical, and orthopedic subjects as well. He was a member of the Mecklenburg County Medical Society, the Medical Society of the State of North Carolina, American Medical Association, American College of Surgeons, Southeastern Surgical Congress, American Board of Surgery, Association of Southern Railway Surgeons, and the Tristate Medical Society. He was the first chief of surgery at the Charlotte Memorial Hospital, and a former Chief of Surgery at Presbyterian Hospital. He belonged to Alumni Associations of Woodberry Forest, Davidson College, Jefferson Medical College and Pennsylvania Hospital.

He was a member of the Myers Park Presbyterian Church, the Charlotte Country Club, Charlotte City Club, Charlotte Chamber of Commerce, Mecklenburg Hounds, and the Benedicts. His interests in nature is exemplified in his membership in many wildlife and conservation societies.

He liked sports, and excelled in them. His favorite hobbies were gardening, hunting, and horseback riding. As a young man he was a good tennis player.

He was a devoted husband and father. He was a Christian gentleman. Men like this are a gift to civilization. We are blessed to have known him.

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